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### INFLAMMATORY AFFECTIONS OF THE FEMALE BREASTS.

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Inflammation attacks the mamma of infants, children and youths of both sexes, women childless or senile may be the subject of this affection, but in the present paper I desire to confine myself to the subject as manifested in the pregnant, puerperal and lactiferous conditions of females, the conditions in which the mamma are functionally active or preparing for the discharge of their duty.

Inflammation may invade the tissue in and about the breasts—as

1st. The involution—

(a.) The skin and integuments, areola glands, follicles &c.

(b.) The suspensory fascia covering and containing the whole breast, and its intra and sub-glandular processes and laminae.

2d. The lymphatic glands, superficial and deep-seated.

Or the structures entering more intimately and essentially into the formation of these—as

3d. The nipple and milk ducts contained within it, constituting the eliminatory apparatus.

4th. The sub-areolar expansion of the milk tubes, called by Sir. Astley Cooper, milk reservoirs.

These reservoirs actually occupy nearly the whole front part of the breast, immediately beneath the integuments and fascia, and lie above the gland in all parts of the breast except the margin, where the hard substance of the gland may be left.

5th. The gland and cellular tissue which pervades every part of it, and is the medium of connection between the lobes, lobules, tubes, vessels and nerves of its substance.

Although very few cases of mammary inflammation occur in which the disease is confined to one structure, and many in which several are simultaneously invaded, yet I think an intelligent anatomical division will conduce to clearer views on the subject. I shall therefore base what I have to write about mammary inflammation upon the foregoing consideration with respect to its seat.

It might be supposed that the integuments or involucra of the breasts were as liable to disease at one time as at another, and hence, at the time when the various processes connected with generation are passing should enjoy their usual exemption from disease, but experience proves the contrary.

It may not be expected that I shall dwell to any length upon the eruptive or specific diseases which may attack the breast, for they may occur at any time, nor erysipelatous and rheumatic affections which more frequently than is generally believed attack the structures. Rheumatism of the fascia of the breasts I think I have witnessed repeatedly. It is manifested by the usual characteristics of it when other parts are attacked. Almost the only sort of inflammation to which the integuments are subject that can particularly interest us now is phlegmonous. Of course the real seat of the inflammation, or at least its beginnings is in the areolar tissue beneath the skin. Generally it is circumscribed and single in locality, often there are several simultaneous or successive foci, less frequently it is quite diffuse, involving a large surface, causing great deformity and damage to the organ, and attended with serious constitutional disturbance.

Phlesmonous subcutaneous inflammation in the breasts is attended with the symptoms which usually accompany it elsewhere, pain, heat, redness, swelling, hardness, tenderness

in the early stages, varying in intensity with the extent and acuteness of the affection. We may generally diagnosticate this from inflammation in other tissues of the breast by isolation. There is usually no trouble in the secreting, eliminating or containing apparatus of the breast. The functions of the whole organ are properly discharged. The inflammation is one generally of inconvenience instead of damage. It is superficial and we may ordinarily get below it so that we can assure ourselves it is outside the *mammæ*. Most frequently the areola is the seat of this disease. There can be no question, however, but that the deep cellular tissue is as often the subject of inflammation as any other of the deep structures, and indeed some good pathologists think it is the seat of disease when we suppose the gland to be the part affected. However this may be, inflammation of any of the deep tissues, generally brings this into the morbid mass. Inflammation of the superficial areolar tissues occasionally involves the reservoirs or glands by contiguity. I have but little doubt that the diffuse inter-mammary suppuration which we see sometimes take place and produce such prodigious quantities of pus, often melts down the connective areolar tissue distributed between the lobes, lobules, and tubes of the organ without always at least attacking the more essential structures. I cannot hope however, nor do I design to try to distinguish between deep-seated cellular and glandular inflammation. The distinction, if made, so far as I can see, would not lead to any favorable result. Chronic superficial cellular inflammation does not often occur, except as it becomes chronic by a long continued succession of small abscesses. It is possible also that the chronic sequela of cellular inflammation as exhibited in hard tumors may be of this character in some instances. When this is the case we should expect to find the hardness not so defined, but shaded off into other parts, somewhat regular in outline, and not sharp irregular and lobulated.

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*Inflammation of the Nipple.*

This may be accompanied with abrasions, fissures or ulceration. Abrasion is most frequently seen on the apex of the nipple, and is the condition in which the delicate epidermis is

removed by action of the child's organs in sucking, leaving the dermis naked, bleeding and raw. It may, however, be observed on any part of the nipple. Not unfrequently these abrasions are increased in depth by ulceration, until a greater or less portion of the nipple may be destroyed. Cracks or fissures likewise often affect the nipple. These cracks are located either on the top, sides, or at the base, of the organ. The apex of the organ, sometimes, is so deeply fissured, as to lay it open to the bottom of this projection, and leave it split in halves; but usually much less extensive, and it simply lays open the top of the nipple to the depth of the skin. The worst fissures that occur on the nipple, however, generally more or less completely encircle the base of the organ. To such an extent are fissures of the base carried by ulceration, sometimes, as completely to amputate this little projection. Abrasions and fissures lead almost invariably to ulceration, and we may consider these as the first stage, so to speak, of ulceration.

This ulceration, of course, resulting as it usually does from abrasions and fissures, occupies the place which I have assigned to them.

The symptoms which accompany these three conditions of the skin of the nipple, do not differ each from the other, and without inspection, we would not probably be able to distinguish between them. There is great pain upon handling the part, or when the child sucks; indeed it is so very severe, as to render it entirely intolerable to the patient, and cause her to resist every request, or even command, to nurse the child. When the child is put to the breast, in addition to the pain, they bleed so as to disorder the milk, and sometimes sicken the child and cause it to vomit up the contents of the stomach. The extent to which ulceration may proceed under the irritating influence of nursing, is sometimes very great.

I remember an instance in a patient affected with stomatitis materna, when the nipple was completely destroyed, and the place where the nipple had been, excavated below the surface before ulceration was arrested. Every experienced physician must have seen cases where the nipple was cleft, cut off, or very badly mutilated. Ulceration has its origin in many cases,

also in small phlegmonous inflammations of the cellular tissue of the nipple. It not unfrequently happens that small pimples arise, suppurate, burst, and on account of the constant irritation of nursing, remain open and pass into a state of ulceration, which is often very obstinate.

Small ulcerations occur in the same way on the areola occasionally, but not with any thing like the frequency, as in the nipple. Neither are they generally so painful as when upon the nipple. The parts being less firm, the swelling does not press upon and distress the surrounding parts so greatly. Such diseases of the areola get well much easier than those upon the nipple, because they are less disturbed than in that place by the child when sucking.

#### *Inflammation of the Lymphatic Glands of the Mamma.*

It is important, in a diagnostic point of view, to bear in mind the frequency of inflammation of these glands. As in other parts of the body, so in the breasts; they inflame in consequence of the passage of acrid or unhealthy lymph through them, derived from inflamed tissues. Ulcerations and abrasions of the nipple and areola are frequently followed or accompanied by the inflammation of these bodies. No doubt enlargement by deposit, leading to chronic inflammation, may also sometimes occur, independent of inflammation. The indolent tumors over the gland and near its margin on the inner, outer and upper circumferences, are frequently chronically inflamed lymphatic glands.

The *symptoms* of inflammation of these glands do not differ in the acute form, from those attendant upon superficial phlegmon. All the distinguishing circumstances of inflammation are experienced. They are more circumscribed than ordinary, the margin is more defined and does not shade off into the healthy tissues, but appears, as it were, encysted. This is the case, however, only at first, as the inflammation often, in fact, I think generally, spreads to surrounding tissues, when the difference cannot be clearly made out.

As the inflammation subsides, there is left for much longer time, hardness, than in phlegmon of the integuments. The acute symptoms merge into chronic, and hardness, tenderness,

and in many instances discoloration, last a considerable time. Suppuration does not occur so quickly as in phlegmon, and resolution much oftener. To make out a diagnosis, we should remember the most common seat of the two. They are ordinarily both (phlegmon and inflammation of the lymphatic glands) small in size, usually not larger than an English Walnut; but phlegmon occurs about the areola, while the other is usually over the located gland, and near its margin. The phlegmon may occur in any direction from the nipple with reference to circumference, but lymphatic inflammation is situated at the inner, or outer-upper edge of the mamma. In scrofulous or broken down patients, a chronic condition of inflammation is likely to take possession of these glands, or they may be filled with albuminous accretions and undergo indolent changes, which might lead the inexperienced to fear malignant disease. I have a patient which has a deep lymphatic tumor in the breast on the axillary margin, who assures me it has been in the same condition for six years. This tumor is hard, round, regular, a little flattish, freely movable, and resembles lymphatic enlargements at the clavicle and groin, in the same patient.

They may be usually distinguished from malignant tumors when indolent and not tender from inflammation, (for malignant tumors are not sensitive in the beginning,) by being more rotoundly irregular, without the sharp outline generally characterizing malignant disease. If they are livid, they are also tender; if they involve the skin, they are tender to the touch, and the skin is inflamed, neither of these conditions obtain in malignant cases. The malignant tumors may be livid and almost insensible, it may involve the skin, attach itself to it, and not inflame it.

The lymphatic tumor is hard alike all over; if softer in one part, that part is the center. The malignant is harder in the center until nearly ready to ulcerate. When the lymphatic tumor has ulcerated, the cavity is regular, and red or pale about the edges, and secretes pus. The malignant ulcer is ragged and exceedingly irregular, in fact, sharp irregularities of edge and cavity mark peculiarly malignant ulcerations—the edges are livid, not red or pale, ichor instead of pus is pro-

duced. In the ulcerated lymphatic there is no smell ordinarily, certainly none but the smell which may arise from uncleanness; a malignant ulcer will smell in spite of us (!) and the smell is peculiar, and when once noticed, will be recognised without difficulty again. Lymphatic glands may be inflamed singly or in numbers, several being the subjects of inflammation at the same time, or only one. As I have before intimated, the disease may be chronic or acute, (indolent or active.)

#### *Milk Abscess.*

Passing to the deeper structures of the breast, we encounter inflammation of the containing portion of the mamma, the expanded milk tubes, the milk reservoirs. There are from fifteen to twenty-five of these expanded tubes, holding from two drachms to an ounce each, in the natural condition.—They are separate and distinct, each tube representing a lobe of the gland. One or more of these may inflame, ulcerate and discharge the milk, mixed with greater or less quantity of pus. Inflammation, followed by ulceration and discharge of pus and milk of these reservoirs, is alone what should be called milk abscess. Abscesses from this part of the breast do not occur singly, as a general thing; several are going on at the same time, one arriving at the ulcerated stage after another: so that we have a succession, each abscess involving one tube, and sometimes, but not often, more. They are seated under the anterior surface of the breast, mostly within an inch of the areola, and sometimes under it. In some persons the reservoirs are large, extend a considerable distance in every direction from the areola, and overlay the gland almost to the margin of the mamma. Milk abscess need not necessarily be near the central portion of the organ, although they generally are not far from the areola. They usually proceed somewhat slowly, taking longer to arrive at the suppurative stage than in superficial phlegmon. Swelling and tenderness are felt near the areola, it increases steadily until an apex is observed in the tumor, the integuments are thinned, fluctuation is observed, and rupture follows. This process requires a very different length of time under different circumstances. If the milk is secreted rapidly, the tube is distended faster; if secretion is

scanty, the advance is slower. The inflammation depends upon distension of the reservoirs by milk which cannot find its way out of the milk tubes. Retention of milk is caused by several different circumstances, which I shall have occasion to mention after awhile. I wish now to be understood as saying, that it is the essential cause of the inflammation in this form of disease. The milk is secreted, but not eliminated, from the reservoir affected; it acts as an irritant by its great accumulation, until inflammation is the result. The secreting capacity of the organ is not necessarily disturbed, and the excretion of the milk may be ready and easy through all of the tubes whose reservoirs are not affected, and we may think it is being evacuated entirely, while it is retained in one or more reservoirs by the stoppage of the nipple tubes. When evacuation, either spontaneously or by the lancet, is affected, pus and milk flow in moderate quantities at first. The pus gradually diminishes, the milk becomes more pure, until a milk fistula occurs, which lasts a greater or less length of time. Should the eliminative tube become open, and allow the milk to flow from the affected reservoir through the nipple, the adventitious opening may entirely heal, and the integrity of the part be restored; but as is most frequently the case, the fistula remains open, until the breast ceases to secrete, all the milk produced by the lobe, whence the reservoir is supplied, flowing out at the place.

Sometimes, again, after breaking and discharging, it suddenly heals up, distension recurs, and the process of ulceration and discharge is repeated.

The sympathetic symptoms are not generally so great as in some other varieties of mammary inflammations. Fever does not run so high, aching of the head, limbs, &c., do not distress the patient so much. Yet they sometimes are quite considerable, and require alleviation by appropriate remedies. The damage done to the breast by inflammation attacking these parts, is not so great as results from glandular inflammation generally, though I have known instances in which nearly all the reservoirs were destroyed, and the breast henceforth remained useless. One of the worst features of the case is derived from the persistent repetition of abscesses, wearing out

the patience of the medical attendant, and the powers of endurance of the patient. It is always complicated by disease or deficiency of the nipple. Besides this ulceration or phlegmonous inflammation of the milk reservoirs, there is another form in which blood and pus are discharged through the nipple tubes, the passage from them being free. Very few experienced physicians but what have seen this discharge of pus, blood and mucus, from the milk tubes, with tenderness and some tumefaction under the areola. It is generally considered to be an abscess discharging in this way, but it is ordinary inflammation of the lining membrane of the milk reservoirs discharging its products through the nipple. Abscesses occurring as the effect of over-distension of the reservoirs, do not give origin to those deep ungovernable sinuses that sometimes trouble us in glandular inflammation, and while there is often milk fistula following them, these close as soon as the secretion ceases, and we have no further trouble.

Several times in my life I have met with these abscesses during pregnancy, in which the accumulation of pus and milk was very great, so that when they are opened, many ounces of pus and imperfectly formed milk were discharged. Several months since I was called in consultation in a case in which the disease had began three months before labor, and when I saw her the child was two months old, and large collections of pus and milk existed, pent up in the reservoirs of impermeable tubes in both breasts, and while some of the reservoirs contained, and their tubes discharged milk, upon nursing, half of them were the subjects of perulent inflammation. Generally the inflammation which causes the evacuation of the milk and pus, checks the secretions of milk, and the patient recovers before the time for labor. This is fortunate when it occurs.—According to my experience, this is the most common of mammary abscesses; indeed I think by a large majority.

#### *Glandular Abscesses of the Mamma.*

This is the most grave of acute inflammation of the breasts occurring during lactation. I am not aware of ever having seen an instance of mastitis proper, unless caused by violence in any other than nursing women. When the inflammation takes

place early in nursing, it usually comes on about the third or fourth day. Mastitis cannot in the first few hours, be distinguished from the intense congestion which occurs at the time the secretion of the milk is first produced. In either case the woman is seized with a severe chill, in which it is not uncommon for her to shake and chatter as in violent ague. In the course of an hour, or sometimes longer, sometimes in a few minutes, the chill gives place to a violent reaction; a high fever, pain in the head, limbs, back, and often abdomen, annoy the patient. All the phenomena of severe inflammatory fever occur. When the congestion subsides into a copious effusion of milk in the cells of the gland, the fever declines, a copious perspiration appears over the whole surface, and comfort succeeds great uneasiness, and sometimes alarm.

When, however, the gland is not completely relieved by secretion, this transition from a state of febrile reaction is imperfect and the patient left with more or less of the symptoms of fever.

Simultaneous with these general symptoms there is pain, tumefaction, tension, heat and tenderness of the mamma. If the secretion is established, the breast, as the sweating stage advances, becomes soft, cool and less sensitive, until it is entirely comfortable. On the other hand, if inflammation is to succeed this congestion, some part of the organ is left in a hard tender condition. A hard lump of greater or less size continues to occupy some deep portion of the breast. Tenderness, tumefaction, heat and redness increase until inflammation is permanently fixed. Without early, energetic and appropriate treatment, the woman will lose part of the mammary gland by destructive suppuration.

In the beginning of glandular inflammation, if the part be attentively examined, the shape and position of the lump will enable us to determine the seat. It will be either deep in the central portion of the breast or in the marginal region. The tunical part is irregularly lobular depressions and elevations may be observed, nodule, not sharp ridges. Very soon after the inflammation begins, particularly should it be advancing, this nodular feel is merged in diffuse hardness of the surrounding parts, until the whole tumor may become smooth and

irregularly defined. Inflammation, hardness and tenderness increase for a few days, when the centre becomes slightly soft at first, growing more so until distinct fluctuation is perceived.

At this time we find a soft fluctuating locality completely margined by hardness all round. This then will be the feeling of a mammary abscess, whether acute or chronic. Glandular abscess differs from milk abscess, by being at first much deeper, having a covering of integuments &c., half an inch or more in thickness, while the milk abscess though quite hard, seems to be immediately beneath the integuments. When fluctuation is *first* perceptible in milk abscess it is shallow; in mastitis it is deep and makes its way slowly to the surface. When pus arrives at the surface, and ulcerates through or is evacuated by the lancet, its flow is much more difficult and the evacuation less complete, relief is not so sudden and perfect. Extensive destruction takes place both in the internal portions of the organ and in the integuments. And so tortuous and irregular are the tracks of transit, in some instances toward the skin, that the pus finds its way out with so much difficulty that the sinuses are sometimes extremely difficult to heal. This state of things may last for many weeks and even months. We not unfrequently find cases in which these sinuses are numerous, tortuous and lengthly so as almost to riddle the internal of the organ, and discharge large quantities of pus, thus draining the system of the woman, inducing hectic, exhaustion and in extreme cases, death.

Often instead of begining at the time of puerperal congestion of the mamma, mastitis shows itself late in lactation. When occuring at such times, it may spring up suddenly, inducing all the general phenomena above described, in a greater or less degree of intensity, or it may be slowly established, and not bring the system into so decided sympathy and perturbation. Yet in the latter case, as the inflammation becomes more completely established, fever is pretty certain to be manifested, its intensity being greater or less according to the extent of tissue involved, the rapidity with which it advances, and the susceptibility of the patient. The first thing noticed, perhaps, is what

the woman would call cake in the breast, of moderate, yet decided tenderness.

This consists in inflammation in one or more lobes of the mammary glands. It gets worse, the swelling becomes greater, tenderness more considerable, instead of the well defined nodular tumor, the swelling is more diffuse—other parts are involved—the areolar tissue around the gland—redness in the skin is observed, sympathetic fever sets in, and then it passes through the different grades above mentioned in the acute variety, with less intensity.

Again chronic glandular inflammation is occasionally observed. At first a deep-seated suspicious hardness is felt in the breast, with barely tenderness enough to make the woman careful about hard pressure. It is usually well defined, nodulated in shape, moveable, and the parts free from morbid color or heat. It may be of small size, only involving one lobe of the gland, or a large part of the breast. In the beginning the distinctive mark of chronic inflammation, is tenderness to decided pressure, when first perceived. As the disease advances, it may of course be recognized by more and more decided symptoms. They are not unlike those I mentioned in connection with disease of the lymphatic glands of the breast. While in very many instances the inflammation of the different parts of the mamma occur separately and may be easily distinguished, we often meet with cases in which the different parts are simultaneously or consecutively involved. Something like the following order of things may take place: Abrasions of the nipple from the act of suckling runs into ulceration, milk abscess succeeds, bursts and heals, or not; mastitis or inflammation of the gland comes next, suppuration from the deep tissues, &c. The long continuance of mamillitis is very likely to be followed by inflammation of the milk reservoirs, and when these last continue, the seat of disease for any length of time, we may look for disease of the gland. There is one or two other points with respect to diagnosis between milk abscess and glandular, that I deem it best to speak of here. When the reservoirs are the seat of abscess, the milk is retained partially,

or wholly, and is evacuated with pus when the abscess is opened.

In glandular inflammation milk is suppressed more or less perfectly, owing to the amount of tissue involved.

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*Causes of Mammary Inflammation.*

As I have intimated, the pregnant puerperal and suckling conditions of women may be regarded as predispositions to mammary abscess. Women are much more liable to them when in these conditions than at any other time. Hence it would not be improper to say that these states of the system are predisposing causes of mastitis and its associate inflammation. The physiological congestion preceding and accompanying the commencement of lactation, very frequently is carried too far, and merges into pathological congestion, and this again into inflammation. When inflammation arises from this cause, it will almost invariably be mastitis or glandular inflammation. This sort of congestion may occur later, but usually it is in the puerperal condition. Another sort of congestion which often runs into inflammation of the glands is brought about by sexual intercourse in very excitable nursing women. I think I have known several instances of this kind. Other passions as anger, may be succeeded by like results. Vascular excitement from stimulants will endanger the breasts in puerperal women also. External causes may give origin to similar sorts of inflammation, as bruises from blows, tight lacing, stays of whalebone, &c. These last (45) are productive of a good many cases. Not unfrequently our patient gets up well from the effects of labor, and the first time she dresses to go out, pinches her excitable gland with lace strings, or punches it with the end of a piece of whalebone during the whole of her round of fashionable calls, and comes home with the breast excited to inflammation. Cold, acting partially upon the person, as the feet, the breast themselves, or even upon the general surface, repels the blood to the already blood-loaded gland, produces congestion as the first step of inflammation. Other external causes operate upon the nipple and surface of the breast, irri-

tate the skin or destroy its integrity, &c. The child often sucks off the epidermis, and by thus abrading the nipple, ulceration is brought about.

Allowing milk or saliva to remain in contact with the delicate skin of the nipple or areola long enough to undergo decomposition, too often is the cause of ulceration, more especially when the saliva of the child is rendered poisonous by the existence of aphthous incrustation upon the tongue, gums, and roof of the mouth. The cracks so often found upon the nipples, I think is almost invariably produced by the habit of allowing the fluids deposited upon the delicate skin to slowly evaporate, and thus carry off, or otherwise neutralize the sebaceous unction of these parts, which is intended to keep the cuticle pliant and soft.

There is a class of causes which I am disposed to call pathological, very prolific of grave mammary diseases. One affection may act in producing another. Thus, ulceration of the nipple prevents proper efforts to draw the milk from the reservoirs; they become distended to a degree that causes inflammation, or the ulceration on the top of the nipple, by the swelling it causes in the inter-tubular tissue, lessens the diameter of the tubes, or entirely closes up their mouths, so that milk cannot find its way out or be drawn, accumulation results, and inflammation follows. Cracks, of course, will do the same; or, again, the inflammation originating on the nipple, may creep down the lining membrane of the milk tubes into the reservoirs, or even farther, through the ramification of the radicles of these ducts, to the substance of the gland itself. In either of these localities, suppurative inflammation may arise, and proceed through all its most aggravated forms. Contiguity of inflamed parts, may awaken inflammation in other parts. Integumentary inflammation, may extend to the reservoirs or glands, by spreading from one tissue to another. There can be but little doubt that acute, and in most cases, chronic inflammation of the lymphatic glands, is generally secondary to inflammation and ulceration of the nipple and areola. It would probably be too strong an assertion to make, to say that inflammation of the lymphatic glands, always has

its origin in this way; for in cases of strong predisposition to this disease—and there are numerous instances of that kind—it would probably arise without much cause of excitement. Certainly, I cannot be mistaken in supposing that I have seen several such cases.

Anatomical causes of inflammation of the breast exist to a great extent. They are sometimes congenital and hereditary, but I think for the most part brought about by improper dressing. The flat, undeveloped, or retarded nipple, is one form of anatomical peculiarity which prevents the perfect performance of suckling, as is represented in figure 1, in the plate. The retention of milk will lead to milk abscess. Nursing is impracticable in this breast. Fig. 2 represents a breast with a very broad but extremely short nipple, entirely too large for a child's mouth, and so short as to add to the difficulty of prehension. Fig. 3 represents a breast with scarcely a trace of the peculiar warty tissue, like nipple, and is simply pouched slightly where the nipple ought to be. A very small nipple, where the milk tubes seem to be bound in such a contracted bundle, as not to allow free egress to the milk, is represented in figure 4.—These four specimens of nipples which we often meet with, are almost impracticable. The first and third, quite so; and the second and fourth, so difficult, that we are generally driven to the necessity of abandoning it, after the best directed efforts to make the breast available. The danger to breasts furnished with such nipples, is that the milk will not be properly evacuated, and that milk abscess will result. In fig. 5 we have a nipple large enough to be easily apprehended, and drawn by the child, but it is too constricted at the base. The milk tubes upon entering it, turn too acute an angle, a little swelling of the sub-areolar tissue from retention of the milk, will stop them entirely up, so that the milk will not pass out. In order the better to illustrate what I mean, I add a sectional view of this kind of breast and nipple. At *a* the milk reservoirs may be seen contracting at the nipple, forming the milk tubes, which turns abruptly upward, and even a little outward. This will be made still plainer by giving what I call a model breast and nipple, fig. 6. It speaks for itself. The nipple is slightly

conical, the base being larger than the apex. I add also a sectional view of this breast. As will be seen, the milk tubes are free from pressure every where. Their entrance into the nipple, is by a slight curve instead of angular turn. The milk will flow spontaneously from this kind of breast, and there can be no accumulation in the reservoirs. In nipples represented by fig. 5, the danger is, that milk, saliva and mucus, will collect in the groove around the base, decompose, and thus induce mammillitis with its attendants and consequences.— This could not well occur in the case of fig. 6. There is no lodging place, the nipple would be wiped clean of all these accumulations by the mouth, and return of the breast inside the clothing of the mother. The shape of the mamma may predispose it to disease, but not in so striking a manner. The more conical a breast the better. A flat sessile mamma is more likely to inflame. Although the above mentioned varieties of nipples are not the only ones predisposing to mammary abscess, yet by drawing the attention of the profession to the subject, thus distinctly, it is believed there will be no difficulty in recognizing adverse anatomical peculiarities whenever they do occur.

It might be appropriate to examine into the cause of these anatomical differences, in the shape of this interesting organ, but the length of my paper will not allow me to indulge in this direction. Like all other formations, the nipple would doubtless differ under the same circumstances in different persons, naturally, but I think there is no doubt, much of the deficiency is produced by tight lacing, and the pressure made directly upon the nipple, for a series of years during its development.

More regard in dressing, as well as education, is bestowed upon fitting the young lady to get married, than to perform her functions properly, after getting married.

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#### *Treatment.*

I can better give my views of the treatment of the affections above described, by observing the same general division with reference to the application of the processes of cure. Inflam-

mation of the nipple will come up in this order of the arrangements for consideration, first. Our means of cure for mammillitis should be arranged under three different heads, as follows: Prophylactic, palliative and curative. The first have for their object the preparation of the nipple for the trials through which it has to pass, at the time of nursing. As has been seen, the causes operating upon it produce abrasions or chaps, and their action is greatly facilitated by the natural and acquired tenderness of the structure, particularly the epidermis and skin. The prophylactic means to be used are such as harden these. As elsewhere, so in the nipple, the skin becomes tough and the epidermic scales abundant and adherent, upon exposure to air and friction. The contrary condition will obtain—tenderness, &c.,—from pressure and covering, with impermeable or large quantities of goods. In this condition it is protected by extraneous covering, and hence does not furnish its own proper defence. The epidermis will be thin and light, and the skin tender. The nipple, therefore, should be covered lightly during pregnancy and nursing. The thinner and more permeable the covering, the better. It should be of such a character as freely to admit the air. At the same time, it should be subjected pretty constantly to moderately rough friction.

An excellent dressing for the nipple for the last two months, is a rough coarse sponge, so cut as to cover the areola, surround and cover loosely, but touch every part of the nipple. Over this there should be but one thin thickness of goods, so as to allow of the evaporation of fluids as fast as secreted, and the free admission of atmospheric air. In cold weather, when going out, the breast of course would be covered by all the over-clothing that are used for the protection of other portions of the person. It is a great mistake to cover these important organs—important on account of their usefulness instead of their beauty—so thickly as they usually are; they bear exposure with great impunity. When we wish to harden the nipples, we should bear in mind the circumstances which harden our hands, and make use of them; we should equally avoid the circumstances that soften our hands. When a lady

wishes to soften and whiten her pretty little hands, she wears kid gloves, and does not allow them to touch hard substances. In a like manner she may soften her nipples, if she should wish to do so. To occasionally moisten them with water and allow it to evaporate slowly on exposure to air, is a good expedient; friction with a dry towel or the fingers, will assist in the process of hardening. It is a matter of great question, whether the various washes used to harden the nipples, are not injurious instead of beneficial. They generally exert a chemical as well as physiological effect, while this last is all that is desired. During lactation, the same exposure to air and lightness of covering should be observed, and after nursing, the nipple should be wiped clean and dry before being returned under the clothing. This is a rule that should never be neglected. Those who have observed the effect of allowing the udder of a cow to dry spontaneously after the calf is taken from her, will understand the importance of attending to this matter. It will be all the better to use a little glycerine or very fine olive oil after they are dried each time, particularly if we have reason to apprehend danger of chaps or cracks. Such prophylactic measures will very generally enable us to avoid the occurrence of distressing chaps or cracks. When, however, the nipple becomes inflamed, these are not sufficient to satisfy the demands of the case, and we must resort to palliative and curative measures, and first of the palliative. As the nipple must be used in order to preserve the function of the breast, and as every time the child sucks, the healing processes that have begun must be more or less interrupted, it becomes important to procure such means as will preserve the breast from the effect of these interruptions as much as possible. The chaps and abrasions that occur, and give rise to inflammation and ulceration, may be located anywhere upon the nipple, at its summit, sides or base, and when the child nurses, the tongue and labia embrace it so closely, that none of these places escape. The artificial means used to palliate the effect of sucking, intervene between the mouth of the child and the nipple, and should be selected with special reference to each case. The shield of ivory or brittania answers very well when

properly managed. They are made in the form of a conical hat, having a rim, a crown cavity, with a draught tube rising out of the top for the milk to flow through. Now, having in mind that these three parts must vary in length and size for different shaped nipples, and cases in which the locality of the abrasions or chaps are different, we will have no trouble in making a profitable selection. The rim should be large enough to cover the areola, the crown or nipple cavity large enough to pass over the nipple, merely touching it on the sides. These things should be observed in all cases. The depth of the nipple cavity is a matter of the greatest importance. If the abrasions or chaps are on the summit of the nipple, it should be so deep, that when drawn, the top of the organ will not touch, or else it will cause pain. There should be no pressure on the top. But if the cracks or abrasions are on the sides, or at the base of the nipple, then the cavity of the shield must be shallow, so that the top of the nipple touches its bottom in such manner as to prevent stretching the organ, and bring the pressure on the top altogether. In this latter case, the bottom of the cavity should be smooth as possible, and correspond in shape to the summit of the nipple, in order to prevent unequal pressure. The shield, of proper shape, size, &c., will afford great relief to the patient, and prevent very much the disturbance to the healing nipple. It is not a matter of indifference either, what material we use as an envelope for the shield.—Gum elastic or cow tets, are always clumsy, and easily become foul or hard, and sometimes taste in spite of our best efforts. Now, I cannot avoid the conviction that a soft linen rag properly adjusted over the draught tube, is better and cleaner than any other envelope. It has the advantage of being cheap and always at hand so abundant, that it may be replaced by a new one after each operation of sucking.

But a very ingenious contrivance is mentioned by M. Legroux, which I will describe :

R. Collodion,	ppts. xxx.
Ol. Ricini,	" ss.
Ol. Terebinth,	" iss.

Mix. This is a fluid mixture which is quite adhesive, and dries less quickly than collodion. It is applied upon the

areola with a brush, so as to encircle—but not touch the nipple—the width of an inch. While yet soft, the nipple is covered by gold beater's skin, and pressed well down around it upon the mixture. The skin adheres to the adhesive material, and thus forms perfect, smooth and pliant covering to the nipple. All that remains to finish, is to prick several holes through the gold beater's skin with a needle, to let the milk through. This has the advantage of not changing the shape, size and feel of the nipple to the mouth of the child, so that it sucks more readily than it would an artificial nipple made with a common shield. But while this is the case, it allows the pressure of the lips upon the nipple at every point, and only partially relieves the mother from the pain.

In the most of cases, I would rely more upon the judicious selection and management of a shield, than this contrivance, ingenious and neat as it is. This may be imitated by other adhesive mixtures and tissues. Before sucking, the gold beater's skin must be moistened with a little sugar and milk. Much of the suffering under nursing, while the nipple is raw from chaps, abrasions or ulcerations, may be avoided by being drawn by the mouth of an adult, so shaping the vacuity produced for the purpose of drawing, as not to touch the sore part. If the lips are so placed around the nipple as to press upon the areola, and not touch the nipple more than very gently—and I am sure this is practicable by any intelligent adult who will make a persevering trial—the draught can be accomplished with comparatively little pain. Violent action should not be used, a gentle but constant pressure with the lips on the areola, with persevering but very gentle draught, will usually suffice, and powerful suction is sure to aggravate the cause of the retention of milk. I have often sat down, and by encircling the nipple with my fingers without touching it, and pressing upon the areola, caused the milk to flow freely, when with great difficulty it could be drawn out. In thinking upon this subject, we should remember that it is the pressure of the atmosphere upon the outside of the breast, combined with the elasticity of the integuments and coats of the milk reservoirs, that urges the milk forward through the nipple into the vacuum caused by excluding it from around the top of the nipple. The vacuum

will not be necessary, if the pressure can be made with sufficient firmness without injury of the part. Why may not some ingenious individual invent a milking apparatus of gum elastic, that by pressing upon the areola and front of the breast, without causing a vacuum on the nipple? This would often save a great deal of trouble and suffering to our lady patients. In thus viewing and treating the subject, we would push the milk out, instead of, as we upon a superficial look at the matter, suppose, pull it out.

The above palliative means do not enable us to *avoid* the causes of inflammation of the nipple; but by their use, we may render the operation of them less mischievous, which is often sufficient in favorable cases to effect a cure. In considering the curative remedies for sore nipples, I must protest against the simplicity with which we use the word, and think of sore nipples. We speak and think of it as though there was no variety of sore nipples. The same treatment is not applicable to abrasions, that is to chaps or cracks, nor to ulceration, nor to all the conditions of ulceration. Nature tries to cure cuticular abrasions by an effusion upon the naked surface of a viscid albuminous layer, thus defending the delicate tissue from contact with atmospheric air, or other irritating substances, and if this is allowed to remain undisturbed, it will, as it falls from the place, leave a well-formed delicate cuticle. And I think the nearer we imitate nature in this respect, the more good we will do. We may use starch or mucilage to cover the abrasions, but any astringent or stimulant application is inadmissible. Abrasions, however, do not last long without becoming ulceration, and the treatment may be different. When there are numerous fine chaps covering a large surface of the nipple, or when single, if very shallow, the treatment for abrasions will usually answer every purpose.—Ointments of a mild unirritating, or even a soothing quality, are probably more applicable than in abrasions. The following is a very good one:

R	Cerat. Alb.	℥ ii.
	Ol. Amyg. Dulc,	℥ i.
	Mel. Desp.	℥ ss.

Mix. Dissolve with gentle heat, and add Bals. Canad 3 iiss,

This should be applied every time after nursing. When the cracks are deep, it is indispensable to quick cure that they should be closed up, and kept so until complete adhesion of their sides takes place. This may usually be done with great facility in the following manner, viz: Press the nipple in such a way as to close the crack, and while thus holding it, apply a thick layer of collodion over the surface. We should apply the layer thickly, and have it extend some distance in every direction, so that it will keep the crack together. The collodion is not easily sucked off by the child, and if the nipple shield be used, it need not be disturbed at all until completely healed. We should watch the coat of collodion, and remove it when it seems to be becoming deficient by violence of nursing. In most cases this covering, if kept up inviolable for a week, will suffice to complete a cure if suppuration is not going on in the chapped place. If this is the case, and the surface becomes an ulcerated one, it will fill up by granulation alone, and falls into the category of ulcerations. In this part of the body, ulceration does not differ from the conditions it assumes in other places, and it cannot be expected that I should dwell upon every variety that may occur. General principles must guide us here as elsewhere. There are two conditions, however, one of which is apt to obtain a prominence and give character to this ulcer, acute and chronic; in either of these conditions the ulcer may be exceedingly irritable to touch, and painful, and in the latter, indolent and atonic. The acute variety is apt to be attended with considerable heat, tumefaction, color and tenderness. These conditions should be removed by depletion, as by leeches, one or two will generally do, cold emollient poultices, large enough for the nipple alone, and removed as often as they become warm. Or we may envelope the nipple in a thin layer of thick mucilage, covered by oil silk, so as neatly to fit the organ, kept cold by ice applied in a minute bladder or india rubber bag, or we may wrap the ice in oil silk.—In whatever envelope it is used, it should not extend beyond the inflamed part, and should be separated from it by a thin layer of cotton wool, or something of that kind.

When such remedies are not necessary because of the non-existence of these symptoms, we should content ourselves in the very early stages of ulceration with similar mucilagenous and bland ointment applications as in abrasions, but as the process goes on, and the acute symptoms entirely subside, astringents become useful, and these will vary in character and strength according to indications of atony and flabbiness, &c. Alum and tannin are excellent applications at first, but will have very little effect after it has continued for any great length of time. Sulphate of zinc and borax will come next in respect to time. One scruple of tannin to one ounce of rose water, five grains of alum, the same quantity of sulph. zinc, are all good in the earliest stages of ulceration of the nipples, when the more acute symptoms have subsided. The following formulæ are often very useful.

R Glycerine, 3 ii.  
Soda Subboras, 3 ss.  
Aquæ Rosæ, 3 iss.

Mix. Use as a wash each time after sucking. Or,

R Soda Subboras, 3 ii.  
Cretæ prep, 3 j.  
Spts. Vini,  
Aquæ Rosæ, aa. 3 iij.

Mix and dissolve. This last may be used when the ulcer is becoming somewhat indolent. Tinct. Kino, Tinct. Nut Galls, and in fact, almost every astringent has been used in these ulcers. In chronic ulcers, still stronger astringents or stimulants will become necessary in conjunction with other remedies. A skillful use of the Suph. Cupri, and Nit. Argent, will do a great deal to heal up and shorten the course of these chronic ulcers. The Nitrate has done the most good in my hands. It should be applied in substance to the surface of the ulcer, and never be used oftener than once in eight days, when a second application becomes necessary. Between times, the ulcer may be dressed with some of the milder astringents, alum or tannin, for instance, in solution. In the irritable variety, some narcotic extract should be made into ointment: Belladonna, hyosciamus, Opium, &c. An excellent expedient, and one that will often entirely change the character of these

ulcers, is to anæsthetize the part with ice, as is directed to be done on a part before the performance of an operation.

We are very apt after we begin to use curative measures, to neglect the palliation. This is a great mistake, for they can have but little good influence, while the causes are allowed to act with all the power that is necessary to produce the disease. We cannot attach too much importance to the measures of palliation.

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*Treatment of Inflammation of Lymphatic Glands.*—The causes of lymphatic inflammation should receive our attention first, as the abraded or ulcerated nipples, inflamed areola or integuments of the breast, or when chronic, the constitutional condition in addition to the local excitements. When acute, they will require in addition, the antiphlogistic measures adopted in other inflammations, leeches, cooling lotions, fomentations, cathartics, &c. When chronic, alteratives, iodine tonics, liniments, irritants, &c., which will be adapted, by every physician according to his own judgement, to the peculiarities of his case. If we are accurate in our diagnosis, and separate this affection from those of the deeper seated structures, there will be no great difficulty in adjusting the treatment of it.

The treatment of milk abscess, is one, however, of greater importance, because of its frequent occurrence and destructive effects. The remedies naturally range themselves into preventive and curative. The prevention has reference to the management of the anatomical and pathological conditions of the nipple, which prevents the free elimination of the milk. Of the latter, I have written quite as extensively as the limits of this paper will allow. Can we change the anatomical deficiencies or depraved shape of the nipple, of congenital or acquired origin? It is a matter of the utmost importance to the health and happiness of the patient, that this question should be decided promptly and properly. Much will depend upon, whether our attention was drawn to the case early in pregnancy, or not until the time of labor, or even afterwards, as to the probability of success in many cases. In other cases,

we can decide the nipple to be impracticable from the first sight, at whatever time we examine it, and I would insist upon the impropriety of compelling a woman to pass through the terrible pain and exhaustion, which attend these cases where the nipple, for instance, is entirely wanting, and prehension impossible, as represented in fig. 1. If our attention be not drawn to the nipple until after labor, and the functions of the breast are required, we ought not to hesitate to decide against nursing, or attempting it. And so far as I am concerned, individually, I would advise against the endeavors to use the breast, represented by fig. 1, if I was aware of its conditions at the beginning of pregnancy. Fortunately this deficiency is rare. When there is an approximation to this, but not complete absence or depression of nipple, the breasts shaped like figs. 2 and 3, much may be done toward rendering them useful, provided our efforts are judicious, and sufficiently prolonged. They should be commenced as soon as pregnancy is known to have taken place; and if in the state of society it were practicable, the prospect of success would be much better, could we have the management of our patients as soon as menstruation began. If mothers were well instructed in such matters, and would carefully attend to it, the probability is, that almost no cases of anatomical unfitness for nursing, would present themselves.

Nipples, represented in Nos. 2, 3 and 4, if not observed by the practitioner, until after parturition, will be almost certain to give us trouble, and in 2 and 3, we will be scarcely able to prevent extensive milk abscesses. The first, and most important principle, is to take perpendicular pressure entirely off the top of the nipple, and this would probably be sufficient to prevent the difficulty, if complete. This little projection on account of the fashions of female dress, is kept constantly pressed back into the soft yielding mammary tissues, until it becomes hopelessly imbedded into them. Now, what we want, is to counteract, and remedy the effect of this mischievous habit. Quite a number of devices have been resorted to, for the purpose of starting the nipple forward from its imbedded condition. They have for their object, as a general thing, the

production of counter pressure around the nipples, upon the areola, and central portion of the breast, in such manner as to press the central tissues beneath the nipple, and thus cause it to protrude. If this object can be effected by such gentle means, continued for a sufficient length of time before the birth of the child, as to make it a permanent state of this organ, the treatment will be effected. The misfortune is, we can seldom get the important desideratum (time,) and we are under the necessity of beginning our treatment, often too late to effect anything. When called upon to remodel a nipple before, or during pregnancy, we may make use of a shield of stiff silver, or iron wire, large enough to embrace, and actually pit the anterior surface of the breast, with a cap-like projection from its center, into which the nipple may project. There may be some soft substance, very thin cotton or wool, to protect the surface from the wire placed immediately beneath it. This should be worn for months under the dress, and receive all the pressure from it, and distribute it over the front of the mamma, and protect the nipple from any pressure. Such a shield is far better than ivory, wood, india rubber, or any other impermeable substance, as it does not interfere with the transpiratory functions of the skin, or the secretion of the areolar follicles, and glandula.

When we are not called upon to treat these rudimentary nipples, until the time of, or after parturition, such treatment will not avail.

The effect must be brought about more promptly, on account of the necessity for immediate use. In many cases the nipple can be made available by temporarily inducing its erection by simple titillation with the finger, moving it gently around it, and then immediately applying the child. An excellent way of erecting the nipple, when there is considerable depression, is to place a thick layer of collodion around it on the areola. When this dries and contracts, the nipple will be elevated quite prominently. The child should then be placed to the breast, and allowed to nurse.

When the nipple is protruded in some of these ways, the milk may usually be drawn, so as to, more or less, completely

empty the reservoirs. This will prevent milk abscess, very generally. When inflammation of the reservoirs has fairly begun, it will be exceedingly difficult to prevent suppuration. The curative means consist in thoroughly evacuating and keeping empty this set of vessels. Several modes of doing this, have been recommended—such as drawing with a glass tube, shaped like a pipe. Various shapes of breast tubes, and pumps are in use, but I must object to *all of these*. It is a very easy matter to injure the delicate tissues of the breasts, by the hard rim of these instruments, and I think the accident often happens.

A puppy is often brought into requisition for this purpose, but is rough, and sometimes irritates the nipple and even sucks the skin off it. The only proper thing for drawing the milk is the mouth, and when these reservoirs are inflamed, it should be the mouth of an adult, who can vary the pressure or force to suit the tenderness of the part. Another very useful class of measures are those intended to suppress the secretion of the milk, and thus relieve the reservoirs from the distension. The narcotic substances taken internally or applied externally to the breast, do a great deal towards stopping the secretion of the milk. Opium in large doses, so as to keep the patient very thoroughly under its influence, aids very much in arresting the secretion of milk. Applied externally in ointments, so as to produce a decided impression upon the system, has a similar effect; but belladonna seems to have acquired most renown for this purpose. Mr. Richard Marley reported forty cases to the Obstetrical Society of London, treated successfully by inunction of belladonna. Dr. Tanner corroborates Mr. Marley's conclusions by his own experience. American physicians testify in favor of belladonna, by furnishing to medical periodicals a great many favorable cases within the last two or three years. It should be remembered that many of the extracts sold in the shops, if not entirely inert, are at least much below the standard in strength. Our opinion of the efficacy of these, of course, will vary from this circumstance, and hence, doubtless the discrepancy in the testimony of different observers in regard to the use of belladonna, for the purpose of suppressing the secretion of milk. The inunction of ointment made with the extract,

should be carried to a sufficient extent to produce some of its characteristic effects upon the system. Its use should be as profuse as the system will well bear. Cold, as a local application in cases of milk abscess, has several good effects. It anæsthetizes the part, rendering the patient more comfortable, it decreases the secretion, constricts the reservoirs of milk, and allays excitement in the capillary circulation. In supplying cold to the breast, the temperature should be about forty or forty-five degrees, and kept as steadily at that as possible. Water of that temperature might be kept running through an india rubber bag enveloping the organ. A bladder partly filled with ice and water, with a piece of flannel between it and the skin, would also do very well. When we do not desire to promote secretion of milk, cold may be used. I do not believe there is any danger from it while its application is confined to the part affected, and its bad effects are usually produced by wetting the clothing, or allowing it to get applied to other parts of the person. I cannot express with sufficient force, the evil effects which the prejudices of a former age in medicine, have fastened upon the minds of at least a part of the public, in the practice of keeping the breasts wrapped in thick layers of cotton or lamb's wool. It is promotive of the secretion of milk by drawing blood to the gland, and thus keeps up the state of things we desire to avoid. For internal treatment, a saline cathartic every other day, and two grains of Iodide of Potassium every four hours, may be relied upon as materially aiding the other treatment. In this affection, antiphlogistic treatment is merely auxillary, and should not be pushed to an extent usually considered necessary in other inflammatory affections. In this case, over distension is the cause of the inflammation, and its removal in the early stages is generally sufficient to cure.

Acute inflammation of the glands of the breast, when it occurs as the effect of congestion immediately preceding the secretion of milk, is apt to be very extensive, sometimes involving the whole of the gland, and will require energetic treatment. For the first few hours, we should try warm fomentations with the hope of establishing the secretion. This probably would be unavailing if actual inflammation had be-

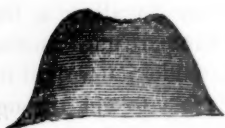
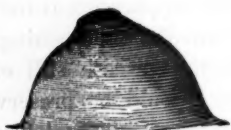
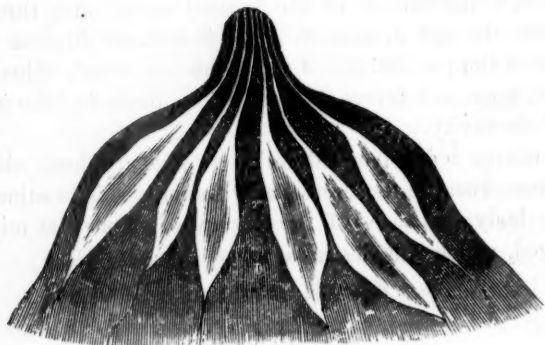
gun; but we cannot always determine the point when this intense congestion passes into inflammation, and hence we are justified, I think, in making the effort. If the patient is robust, and the fomentations fail wholly or partially to bring relief, a decided venesection will often turn the balance in favor of resolution. When we bleed, the object should be to produce a decided impression; and in order to do this, the patient should be in a sitting posture, and the blood allowed to run until the pulse is affected and syncope approaches. I have so much faith in *verat. viride* in combating inflammation, that I should begin its use immediately after *v. s.*, and if the patient is strong, give it in six drop doses every four hours until the pulse is brought down to sixty in the minute, and then by administering it in decreased doses, keep it as nearly at that as possible. One grain of calomel with a quarter of a grain of sulph. morph., may be given occasionally, if the pain is urgent, every four or six hours. This kind of promptitude and energy of treatment, will frequently arrest the inflammation and bring about resolution. And when we remember the amount of suffering and damage it may prevent, nothing should deter us at least from urging our patient to accept the treatment.—Should this not be sufficient, it is an important question whether depletion can be carried further. One good full general bleeding, if followed by *veratrum*, will be sufficient generally; but sometimes it will be expedient to use leeches, and produce a general alterative mercurial influence. A lotion made of one part of sulph. ether to two parts of alcohol, will be a good soothing adjunct after the inflammation becomes permanent. If the inflammation begins later, the extent of disease is apt to be less, and may be confined to one lobule, or at most, a part of the gland only. In this case, a brisk cathartic of calomel, aided by some saline, leeches to the part, followed by cold lotions, *tinct. verat. viride*, or solution of *tart. ant.*, given at sufficient intervals, in proper quantities, will afford us efficient treatment. If this treatment is begun early, we may expect much good from it. It has always been an interesting question with me, after the inflammation has existed for a length of time, and we cannot avoid the formation of pus, whether we

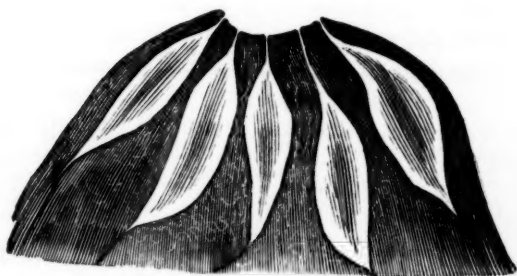
should abandon antiphlogistic means and resort to warm poultices and fomentations to promote suppuration. I think that this is not justifiable in many instances. The probability is, that if we continue our general and local antiphlogistic treatment until suppuration is clearly evident, we may limit the extent of that termination, lead to resolution in a larger part of the gland than would otherwise take place, and thus save much of the glandular tissue. When the *whole gland* is inflamed, there is no necessity, in fact I think it injurious to institute and continue strenuous efforts to draw the breast. There is little or no secretion, and when a part of the gland only is inflamed, and milk is produced by the rest of it, it is questionable whether anything but the most moderate means for this purpose are admissible. Retained milk is not the cause of inflammation in this case as in milk abscess. Very frequently glandular inflammation is complicated with inflammation of the reservoirs; then we must combine our treatment to suit the case, local and general antiphlogistic, with means to arrest the secretion and empty the reservoirs of the milk already contained in them.— Chronic inflammation of the gland will be cured by much the same treatment successful in other glandular inflammations of this grade; leeches, mercurials, iodine and vegetable alteratives perseveringly administered internally, and locally applied. Much reliance can be placed upon well regulated and graduated pressure, with adhesive straps pressing the part diseased, against the ribs; or collodion encasing the breast thoroughly. When suppuration has taken place, what are the indications to be relied upon to justify us in evacuating it? There can be no doubt, I think, that the earlier the matter is let out the better for several reasons. The cavity becomes larger by allowing it to remain, it burrows through the surrounding tissues; the longer it remains, the greater the amount and duration of the irritative fever that accompanies its retention. But notwithstanding the desirableness of getting rid of the pus, we should hesitate to cut through uncondensed tissue to any extent. In cases where the inflammation and suppuration are deep in the gland, it is desirable to wait until the pressure from within has lasted long enough, and in a suffi-

cient degree to cause the condensation of the tissue. Otherwise, it will require a very large opening to allow a free discharge. I think we should not lance the part until fluctuation is quite evident, and the pus has made its way to the fascia or integuments. It is never desirable to cut through any part of the uninjured gland or milk ducts, and altogether, I should feel more inclined to allow it to approach the integuments very closely before cutting.

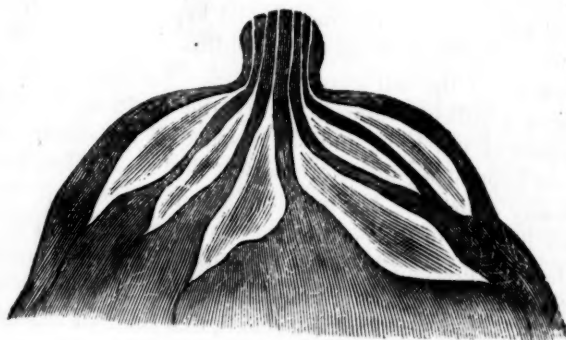
In the case of milk abscess, the earlier the opening is made, the better. As soon as it is evident that suppuration is inevitable, the opening may be made. The smaller the opening, to allow the escape, the better. Should the disease still exist that caused the retention, the opening should be preserved. Often the evacuation of one or two reservoirs will suffice, and the rest will continue to discharge through the nipple. The effect of suppuration, and evacuation of a milk reservoir, is often to entirely destroy its cavity, but in other instances, it continues to discharge through the artificial opening, and a milk fistula remains. This may be closed by an occasional application of the nitrate of silver in pencil. Worse than these are the tortuous lacuna, that sometimes result from the deep glandular abscess of the breast. They are generally difficult to cure. Injection of iodine, is the remedy most relied upon for these troublesome sequences to suppuration. The most effective way to inject, is to insert a soft flexible catheter, if possible, to the bottom of the twisted canal, and throw the injection through it, so as to apply it without dilution to the bottom of the pus fistula. I think this important, when practicable, because it favors the shallowing, instead of the narrowing of the cavity.

Of course it is never advisable to slit up these obstinate puriferous ducts in the breast, as it sometimes is in other parts of the body, because, of the amount of tissue that might be damaged, which it is desirable to save.

*(Fig. 1.)**(Fig. 2.)**(Fig. 3.)**(Fig. 4.)**(Fig. 5.)**(Fig. 6.)**(Fig. 6.) Interior view.*



*(Fig. 1.) Interior view.*



*(Fig. 5.) Interior view.*

## NOTES OF SURGICAL CASES.

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By E. ANDREWS, M. D.,Prof. of Surgery in Medical Department Lind University.

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*Talipes Varus and Valgus in the same patient. Operation and Cure at twenty-five years of age.*—Mr. L——, of Southern Indiana, aged twenty-five years, called upon me with the view of having a leg amputated, on account of a very bad talipes varus which rendered the limb a burden to him. On examination and inquiry into his case, I found it as follows :

When an infant, the left foot was sound, but he had some disease in the right foot which caused it to turn outward, constituting a case of talipes valgus. As it was never straightened, he grew up walking upon the inner side of the foot, and the end of the malleolus. On examination, I found the member of good shape, but small and illy nourished. The peronei muscles were contracted, and kept the foot in its faulty position. No trace of the tendo achillis could be found, and the muscles of the calf were atrophied. On the whole, it did not seem a difficult thing to rectify the position, though the feebleness of nutrition, and the absence of the tendo achillis gave no hope of a completely perfect limb. The left foot was vigorously nourished, but much more out of position. It was turned inward, in the position of varus, so far, that in walking the sole presented obliquely upward, and the bones were so altered in shape, as to render a complete restoration of the form impossible. The patient stated, that this foot was reduced to its present condition by an accident, which dislocated the ankle when he was a boy, and for some unaccountable reason, the dislocation was not reduced. For this foot he simply desired amputation. After a careful examination, I decided upon attempting a restoration of both feet to the natural position.

Commencing with the left, as being the worst, I severed the tendo achillis and the tendon of the tibialis anticus. Upon endeavoring to straighten the foot, it was found that no amount of force would accomplish it. I therefore made a crucial

incision over the external malleolus, and with the saw, resected the ankle joint, removing the lower extremity of the tibia and fibula, and upper part of the astragalus, the whole constituting a wedge shaped mass. The foot was then brought easily around with the plantar surface in its proper position.

On the third day the wound was attacked with erysipelas, which extended to the whole foot, producing several abscesses, and two sloughs. For this, the patient was treated vigorously with tinct. iodine, and ice externally, and mur. tr. iron, every two hours internally. After a few days the erysipelas was subdued, but the ulcerations consequent upon it, were very slow in healing. There was no necrosis. The correct position of the foot was maintained, and long union took place between the astragalus and tibia. At the present time, the last remnants of ulceration are healing slowly, and the foot, though short and *clumpy* in form, will make a very respectable appearance.

Some weeks after the first operation, I proceeded to straighten the right foot, which was affected by valgus. In this case there was much less difficulty. The patient being put as before, under the influence of chloroform and ether. I severed the tendons of the three peronei muscles, and the external lateral ligament of the ankle; then seizing the heel, I forced the member into its proper position. The pressure of the splints and dressings, necessary to maintain the position, was poorly borne by the enfeebled tissues, and several ulcerations occurred, nevertheless, the result was a success, and the position of the foot is now correct, and its form perfect.

*Cataract.—Operation by Solution.*—James ———, aged ten years, appeared at Mercy Hospital with cataract of both eyes. As the retina appeared perfect, the patient being able with ease to point out the position of conspicuous objects, I decided to operate. I chose the method by solution. Having dilated the pupil with solution of sulphate of atropine, and anaesthetized the patient, I introduced a cataract needle at the lower part of the cornea, and lacerated the capsule of the crystalline lens. The opaque contents of the capsule began immediately to bulge into the anterior chamber, and the pupil

contracted to its former size. On the third day I removed the adhesive straps from the lids, and examined the eye. The contents of the capsule turned still more opaque by the action of the aqueous humour, were projecting in a columnar form into the anterior chamber. There was no inflammation. From this time forward, the case steadily progressed. And at the present time, (six weeks after the operation,) the pupil is nearly clear.

The simplicity and safety of the operation by solution, ought, I think, to commend it to more frequent performance. In the country particularly, where the general practitioner may not have all the instruments, and the experience necessary for a safe performance of extraction, he might still, in many cases, operate by solution; thus restoring the vision, and keeping his patient from being victimized by some wandering quack.

Another advantage of this operation is, that it is much safer for the eye, and may be practiced upon both of them without rashness, allowing of course, a sufficient period to intervene between the two operations.

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### CASE OF POISONING BY LAUDANUM.—COLD WATER TREATMENT.

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By H. WARDNER, M. D.,  
Demonstrator of Anatomy in Lind University,

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*Case 1st.* Miss Marion ———, in a fit of anger swallowed an ounce of Laudanum, fortunately, in the presence of the family. Happening to pass the house at the moment, I was called in, and administered a full dose of tartarized antimony, within five minutes from the time the Laudanum was taken. A free and prompt emesis followed, expelling it entirely from the stomach. In three hours, she was as well as usual; no doubt, secretly congratulating herself upon giving her friends a fright, and escaping the slightest harm.

*Case 2d.* A Miss B———, of this city, in a violent fit of jealousy, drank between one and two ounces of Laudanum.

Some thirty minutes or more elapsed before I saw her. A large dose of tart. emet., was at once administered, and followed by copious draughts of warm water. Although the opium had not very perceptibly effected the brain, yet the emetic was slow to act. Upon pouring cold water on her head, a prompt action took place, and the stomach was relieved of the drug, together with an enormous supper with which she had fortified herself to meet death. There were no subsequent effect worthy of note.

*Case 3d.* In the fall of 1859, I was called to see a girl, who, as was afterwards ascertained, had taken an ounce of Laudanum, about six hours previous. She was found upon the bed by the family, where she stopped, who were unable to arouse her. Her appearance answered the descriptions of opium poisoning. I tried various means for arousing her, in vain, until, after thrusting pins into her hands and feet for a while, I observed some slight twitching of the muscles. She was then taken out of bed; her head held over a tub; and I poured upon the top of it, a stream of cold water from a pitcher three or four feet above her head, for nearly twenty minutes, when she drew a deep, full breath, partly opened her eyes, and shortly after vomited. I kept up the stream of cold water, till she begged me to stop. I then gave her very strong coffee, and shortly had the satisfaction of seeing my patient fully recovered, satisfied with the folly of self destruction.

*Case 4th.* In June last, I was called to see Miss Emily C——, who an hour previous, had taken full two ounces of Laudanum on nearly an empty stomach. Found an "apothecary doctor" with her, who had managed to keep her partly aroused. She had obstinately refused to take anything, and was said to be past swallowing. I prepared a powerful emetic, which she refused, saying indistinctly she "could not swallow it." But *take it she must, and did.* Her obstinancy being conquered, a deep stupor came speedily on.

The cold water was then used as in case No. 3, after a little delay, emesis occurred repeatedly. For five or six hours, she was in a state more or less comatose. Cold water was poured upon her head at intervals of ten to twenty minutes, until she

was at each time aroused, so as to answer questions, and beg for mercy.

The effects of the drug at length passed away, and she recovered after a few days of illness, during which there was a strong tendency to dysentery.

This method of treating these cases, has thus proved very satisfactory. It is a means of treatment always at hand, and recommends itself to the public, as well as the profession.

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### PARAPHLEGIA CURED BY THE USE OF MAGNETIC ELECTRICITY.

BY DR. J. CERF, OF WHEELING, ILL.

The cause of this severe malady is sometimes in the head, though more frequently in the spinal marrow. The symptoms of this form of palsy are as variable as the causes. With some, the disease commences with slight occasional pain referable to a part of the hip, thigh or leg, and frequently behind the protuberance at the head of the femur bone. Pain is not always present; fatigue frequently induces it, and rest relieves.—Weakness and pain now manifest themselves in the muscles at the lower part of the back, or in various parts of the legs. At times, the patient cannot walk, or even stand erect, without a paroxysm of pain following, which compels him to assume a recumbent position, as the only mode of obtaining partial relief. Locomotion is performed with difficulty; the legs threaten to give away, and bend under the patient at every step. After an interval of months or years, the legs become incapable of carrying the body beyond a few yards, and sometimes the erect position cannot be maintained, while the power of moving the legs may remain, and sensation be unaffected. Generally, a wasting of the paralysed limb is apparent, while sensation may be morbidly increased. On sudden and rapid changes of weather, the patient is attacked with painful neuralgic twitches, resembling those of *Tic-Douloureux*. The patient lives in this state an indefinite period.

*Case.*—Samuel Haegi, 17 years old, a robust looking young man, plethoric and strongly built, has suffered from an attack of paralysis. On the 15th of May, 1860, this young man was brought here to my office: it took 3 to 4 men to get him from the wagon. He could not walk without being assisted by somebody. His knees gave away and bent down at every step. Sensation was entirely gone, except by hard pressure. When I placed them in warm water, they showed bluish spots on different parts of his entire limbs. The lower and upper extremities were cold and trembling. He complained of no pains—was regular in his bowels, but not so with his urine, which was scanty. None of his family, ascending and descending, have been peculiarly disposed to hereditary disease.

*Treatment.*—I prescribed—

R. Strychina,	Gri.
Sulph. Acid. Arom.,	ʒi.
Aquæ Destil.,	ʒv.

Mix. 1 teaspoonful 3 times daily. Empl. Canth. 2-3 inches upon the Lumb. Vertebra, and Antim. Potass. Tart. ʒi. Ung., Sempl., Mix. Ft., Ung., to be rubbed on the limbs every morning and evening, applying the Magnetic Electricity twice every day, and continue this treatment for two months in succession, with the exception, in place of the Antimon. oint. I use

R. Delphinia,	ʒi.
Ung. Simpl.,	ʒi.

Use as with the Antim. oint., and my patient has entirely recovered, and is now enjoying as good health as ever.

### CLINICAL REPORT.

Medical Wards of Mercy Hospital. Service of Dr. N. S. Davis.

Reported by C. DUMREICHER.

The time this morning for clinical instruction, was occupied with two cases, one of Chronic Dysentery, and one of Continued Fever. Mr. ———, aged ———, was admitted to the Hospital. He had been suffering from dysentery for more than a year. He had been for some time under treatment in one of the Hospitals of New Orleans, and subsequently in a

Hospital in this city with only temporary benefit. From the character of the discharge, it was probable, that the inflammation extended from the upper part of the Colon into the lower part of the Ilium. The case gave rise to a more close and careful inquiry into the different pathological conditions, constituting chronic dysentery and diarrhœa. The first and most frequent condition was stated to be simple inflammation of the mucous membrane of the intestines, causing in its more chronic form, a thickened and indurated condition of the mucous membrane, and resulting in ulceration, which attacks any part of the intestinal canal indiscriminately.

The attention of the class was called to the difference in the pathological appearances of the intestinal canal in dysentery, and in typhoid fever. It was remarked, that while in typhoid fever the ulceration is limited to the glandular structures, and involving almost always the mesenteric glands, in dysentery this ulceration extends indiscriminately to all the structures of the intestinal surface, and attacks very seldom the mesenteric glands.

As a second condition giving rise to chronic dysentery, was enumerated local ulceration of the intestinal canal, not unfrequently the sequel of typhus and typhoid fevers. In these cases, it will almost always be found, that enlargement and softening of the mesenteric glands has taken place also.

Tubercular deposit in the mucous membrane of the intestinal canal, was given as the third and most fatal condition, giving rise to dysentery. If the disease resists all rational treatment, and particularly if connected with tubercular deposits in the lungs, we may confidently predict the existence of tubercular deposits, situated in the mucous follicles of the intestines. In many of these cases the patient will not complain of any cough, or only very little; but this ought not to mislead the practitioner, as a perverted sensibility accounts sufficiently for it, while by the aid of the physical signs, auscultation and percussion, he is enabled to determine with correctness and certainty the presence of a disease of that kind. The case showed very plainly how necessary it was to understand the true pathology of these cases, to give a correct prognosis.

The history of the present case indicated that it belonged to the third of the above divisions. A careful examination proved it to be so. The space immediately beneath the clavicle, appeared to be sunken; the inspiratory murmur was short, while the expiratory was rather prolonged; the increase of the vibration of voice was strongly marked, indicating an atrophied condition of the upper part of the lung, with increased density. The condition of the blood has become considerably changed; the corpuscles are diminished in number, while the watery portion is relatively increased.

The indications for treatment, are according to the pathology given above, unmistakable. First endeavor to keep the bowels as quiet as possible, by diminishing the peristaltic action of the intestinal canal, and allaying the morbid sensitiveness of the involved parts. Second, to promote a more ready cicatrization where ulceration has taken place. Third, to improve the quality of the blood. The *nit. silv.* was recommended in combination with opium, to accomplish the two first objects. The sulph. of iron and copper were mentioned for the same purpose. Acting differently, but yet designed to accomplish the same objects, were mentioned the oil of Turpentine and the gum Benzoin, given with opium prepared in the form of emulsions. The sulph. of Iron and subnit. of Bismuth were alluded to as sometimes valuable for increasing digestion by invigorating the stomach.

During the two proceeding days, the patient has been taking a pill every two hours, containing *Nit. Argent*  $\frac{1}{3}$  gr., and *Pulv. Opii*. 1 gr. At present this pill was directed to be continued every four hours, and alternated with a teaspoonful of the following emulsion, viz:

R	<i>Pulv. G. Benzoin,</i>	3 ii.
	<i>Tinc. Opii.</i>	3 ii.
	<i>Pulv. G. Arabac,</i>	} aa. 3 iii.
	<i>White Sugar,</i>	
	<i>Mint. Water,</i>	
		3 ii.

Rub together for an emulsion.

For nourishment, the patient was advised to live exclusively on Milk with Lime Water, or Milk Porridge. This course of treatment was continued for two days with considerable relief,

but at the end of that time the discharges became more frequent; and the following powder was substituted for the pill of Nit. Argent, and Opium, viz :

R	Oxide of Zinc,	3 qrs.
	Tannate Quinine,	2 qrs.
	Pulv. Opii.	1 gr.

Mix one powder.

The same nourishment was continued. After continuing these powders alternated with the emulsion three days, the discharges had become less frequent and painful, but the patient was much debilitated. The emulsion was then omitted, and the Liquor Ferri. Nitratis 15 gtts. given every four hours in its place, the powders being continued, and same nourishment as before.

This treatment has been continued until the present time, (three weeks since the patient was admitted,) and his discharges are reduced to about three in 24 hours, are more natural, and the patient has gained decidedly in flesh and strength.

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*Typhoid Fever.—Pulmonary Engorgement.*—The second case to which our attention was called during the clinic hour, was that of a German aged about 18 years. He had been admitted into the Hospital ten days previously. At the time of admission he presented all the ordinary phenomena of an idiopathic fever. His skin was hot and dry; his face flushed with a diffused redness; his expression dull and mind gloomy; his tongue covered with a dirty white coat; sore throat; pulse 110 per minute, but not full; bowels inactive; with much dull aching pain in the head, back and limbs. All these symptoms were much diminished during each morning, constituting a well marked remission. But there was neither a well marked chill nor a sweating stage. The attention of the clinical class was directed to the case at that period of its progress, as one presenting the interesting questions of diagnosis between paroxysmal or *exacerbating* cases of continued fever, and those of true *remittent* or malarious fever. It was remarked that many cases of continued fever, during the early part of their progress, present such distinct daily exacerbations and remie-

sions, that they sometimes lead even the experienced practitioner into doubt, as to whether they are actual cases of continued fever or genuine remittents. If such cases are scanned closely, however, it will be found that the exasperating continued fever patient always presents a dullness of expression, a dingy suffused redness of the face, red and dry lips, obtuseness of the mental faculties, and a quick soft pulse, which is widely different from the more anxious and active expression of countenance, the bright flush on the cheeks, the acuteness of the special senses, the more full and active pulse, the more sallow hue of the skin, and more frequent billious vomiting, that generally accompanies the paroxysm of a Remittent. Although Prof. Davis remarked at the first interview that the present case would doubtless prove to be one of Typhoid Fever, yet as it was plainly exasperating and many practitioners thought Quinine valuable, to say the least, harmless, he would prescribe the following course of treatment.

R	Spts. Nit. Dulc.,	3 i.
	Qinct. Opii. et Camph.,	3 i.
	Tinct. Verat. Viride,	3 i.

Mix, and give a teaspoonful every three hours during the afternoon and evening while the febrile exasperation continues.

R	Sulph Quinine,	12 grs.
	Pulv. Opii.,	3 grs.
	Blue Mass,	6 grs.

Mix, divide into three powders, and give one at 5, 8 and 11 o'clock, A. M., constituting the period of remission. This course was followed for three days in succession, when the active febrile exasperations ceased, the pulse became slower, the headache ceased, and all the phenomena of fever were diminished, but at the same time the bowels began to move too frequently, the discharges being thin and brown. Both the previous prescriptions were now omitted, and the following emulsion ordered in doses of a teaspoonful, with two grains of Sulphate of Quinine added to each dose when taken.

R	Ol. Terebinth,	3 ii.
	Tinct. Opii.,	3 ii.
	Pulv. G. Arabac,	} aa. 3 iii.
	White Sugar,	
	Rub together and add	
	Mint Water,	3 ii. Mix.

This checked the intestinal discharges, and for two days the symptoms indicated a speedy convalescence. At the end of that time, however, the tongue became more dry and brown; the mind of the patient constantly wandering; the pulse quicker; the skin more dry; the bowels slightly tympanitic; and still two or three liquid brown stools in the 24 hours. There was also noticed at that time an occasional dry bronchial cough with dry bronchial rales on both sides of the chest. To counteract these symptoms the emulsion was continued, and 15 drops of chloroform given between each of the doses. The patient was also allowed to take pretty freely of a solution of chlorate of Potassa. Notwithstanding these remedies, the lungs became every day more engorged, and the breathing in consequence more noisy and difficult; the bowels continued to move three or four times a day; the hearing became dull; the delirium constant; some sub-sultus; the pulse soft and frequent; and the impulse of the heart feeble. At the suggestion of another the patient was allowed to take brandy punch freely, in addition to the other remedies, but instead of ameliorating the condition of the patient, thirty-six hours after its use was commenced, the passive engorgement of the lungs had so much increased that the patient appeared in a hopeless condition.—At this time the attention of the class was called to the patient, and the symptoms and treatment carefully reviewed. Prof. Davis expressed the opinion that the engorged condition of the lungs was altogether passive, resulting, like the delirium, the sub-sultus, and the cardiac weakness, from the failure of those elementary properties which we call susceptibility and vital affinity, and in consequence of which the blood fails to make its wonted impression on the capillaries.

English and American pathologists very generally refer this state of things to a failure of *innervation*, and hence endeavor to remedy it by the free use of Alcoholic and other diffusable stimulants. He was satisfied, however, that the failure of innervation in these cases, was not the *cause* of failure in the functions, but only a co-incident, and itself dependent on the alteration of the properties common to all the tissues, as just mentioned. A close scrutiny and rigid analysis, will enable

the practitioner to arrange all the more grave cases of typhoid and typhus fevers into four classes. The first includes those cases in which the life of the patient is endangered from direct failure of the cerebral functions; the second, those in which the most alarming symptom is feebleness of the heart's action and impulse from an early tendency to softening of its muscular structure; the third, those in which the respiratory function is seriously impaired from early and progressive engorgement of the pulmonary capillaries; and the fourth, those in which life is endangered by the continued disease and ultimate disorganizations of portions of the mucous membrane of the intestines. The results of his own experience had led him to regard the use of alcoholic stimulants as positively beneficial in the first class of cases only. On the second and fourth, they produce little or no effect, while on the third, their influence is positively injurious. And as the case before us plainly belonged to that class, he directed the brandy punch to be discontinued.

He stated that the only hope of restoring such a case as the one before us, consisted in the adoption of some remedy, or combination of remedies, that would increase the susceptibility of the nervous and muscular structures, by which the heart's action would be invigorated, the tone of the pulmonary and other capillaries improved, and the progress of passive engorgements and softening of structures arrested. For producing these effects, we were familiar with no remedies more reliable than Strychnine and Oil of Turpentine. Hence, he directed the patient to continue the use of the emulsion in doses of a fluid drachm every four hours, and gave alternated with it a teaspoonful of the following mixture:

R	Strychnine,	1 gr.
	Nitric Acid,	3 i.
	Tinct. Opii.,	3 ii.
	Water,	3 ii.

Mixed. Beef-tea well salted, and milk porridge had been given the patient for nourishment, and the same was continued. At our next visit to the ward, two days after, we found all the symptoms of the patient much improved.

There were less delirium; less oppression of respiration; a fuller pulse, and less frequent evacuations from the bowels. The same remedies were continued, but the doses given at longer intervals. Three days subsequent we found the patient fairly convalescent, but very weak.

The evacuations from the bowels having become natural, the emulsion was discontinued, and the Strychnine Solution continued as a tonic three or four times a day. The patient slowly recovered his health. In reference to the use of Strychnine in continued fever, the doctor remarked, that in many cases between the fifth and fifteenth days, the impulse of the heart becomes weak, the voluntary muscles unsteady, the capillary circulation feeble, with an evident tendency to passive congestions in some of the internal viscera; and in such he had seldom failed to find the remedy strikingly beneficial. This was well illustrated in a case of Typhus, in a young woman directly from an emigrant ship in New York, which was admitted to the Hospital, and brought to the notice of the class a few weeks since.

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#### BOOK AND PAMPHLET NOTICES.

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ON THE DISEASES, INJURIES AND MALFORMATIONS OF THE RECTUM AND ANUS. WITH REMARKS ON HABITUAL CONSTIPATION. By T. J. Ashton, M. D.

Blanchard and Lee have just issued a reprint of the third Edition of this valuable work, which made its appearance during the present year in London. This edition has been carefully re-written, with such additions as the author's extended experience permits him to make, to the present time. The present edition is finely illustrated, which gives it decided preference over the former ones.

These illustrations have been re-produced in the American edition, with the characteristic fidelity of the enterprising publishers.

The volume, containing nearly three hundred pages, describes in a concise and lucid manner, the various diseases to which this portion of the body is subject, and the most successful means of palliation and cure.

It treats of irritation and itching, of inflammation and excoriation, of excrescences, contractions, fissure and neuralgia of the anus, devoting a chapter to each topic.

The causes, symptoms, complications and treatment of inflammation and ulceration of the rectum, comprise the two very valuable chapters next in order.

The subject of Hemorrhoidal affections, with a citation of some thirty cases, with the treatment and result detailed, is of special interest and afford much valuable instruction upon this particular point.

Abscesses, fistula, polypi and strictures are briefly but ably treated of; while malignant diseases of the rectum, injuries, malformation and the effects of foreign bodies, are amply noticed.

The concluding chapter upon Habitual Constipation is worthy of particular attention, and if our space permitted, we should be inclined to present it entire for the benefit of our readers. The author remarks:—"Habitual Constipation is one of the most prevalent and troublesome functional disorders to which mankind is subject. Its sympathetic effects extend to every organ of the body, and often occasion great distress and anxiety to the sufferers, leading them to apprehend the existence of the most serious organic disease. Neither can it be doubted that many of the pathological changes in structure of the viscera of the head, chest and abdomen, have their origin in functional derangement, induced either sympathetically by constipation and consequent derangement of the assimilative organs, or by retention of excrementitious matter.

"Of the sympathetic effects upon the brain and nervous system thereby induced, we have evidence during infancy and youth, in convulsive fits, chorea and other nervous affections, and in adults in the giddiness, drowsiness, headache, pains extending to various parts of the body, and that distressing mental depression denominated hypochondroasis, which not unfrequently terminates in permanent perversion of intellect or even in a more distressing manner. The sympathetic effects upon the lungs and heart are indicated by cough and palpitation. The reaction on the stomach is marked by disordered appetite, vomiting, eructations and a sense of gnawing and

sinking at the precordia. We have evidence of the kidneys being affected in their morbid secretions, as marked by the various deposits we find in the urine.

"The exhalent functions of the lungs and skin also become deranged, as indicated by the fœtor of the breath and perspiration; and many of the distressing and unsightly diseases of the skin, have their origin in constipation and morbid accumulations in the bowels.

"Nor do the genito-urinary organs escape; thus urethral, vaginal and uterine discharges and irritability of the bladder are frequently induced.

"The countenance of those who are the subjects of habitual constipation is dull and heavy—the eyes lack their lustre, and the tongue is observed to be deeply notched transversely."

He proceeds to remark upon the most common causes of constipation, depending upon torpor of the color, and the means of avoiding that condition. The *subjects* of this affection are those whose powers of life are naturally low—in the earlier period of life, more frequently delicate females; but as age advances and the organic functions become enfeebled, we find it prevailing in either sex.

The most frequent accidental *causes* are sedentary habit, and a very common practice of *not attending to the first calls of nature to evacuate the bowels.*

The loss of contractility of the intestines from enormous and frequently unnoticed distention of the colon, brings as its sequence a vast train of evils.

In the treatment of habitual constipation, the author adds, "the object to be obtained is the removal of the cause; to procure fœcal evacuations by the mildest and least irritating means adequate to the purpose; to restore the lost tone, and to prevent the recurrence of the torpid condition of the bowels."

The appropriate and the *injurious* agencies resorted to for the accomplishment of these purposes, are pointed out, and his judicious advice with reference to the *habits of attention to the state of the bowels*, with reference to *food exercise, occupation, &c.*, will profit the practitioner and the patient. We deem it the best work of the kind which has yet been presented to the medical profession.

J. H. H.

## WALSHE ON DISEASES OF THE LUNGS.

Walter Hayde Walshe, M. D., is already favorably known to the Medical profession of the United States, as well as of Great Britain, as an eminent authority on diseases of the lungs and appendages, and the present edition of his work, from the third revised and enlarged London edition, will be found a valuable accession to this branch of Pathological literature.—The work before us is much fuller and more complete than former editions; containing, besides more elaborate details of diagnosis, prognosis and treatment—points of especial interest to the student—considerations of diseases not previously mentioned.—His style is forcible, clear and concise; the instructions for inspections, and the descriptions of the various phenomena of sounds, murmurs, signs, &c., precise, graphic and unmistakable. We are tempted, however, to observe that the section on *Change of Climate* might have been profitably omitted by the American Publishers; ignoring, as it does, almost totally the existence of the North American Continent, with its almost endless variety of climatic and atmospheric conditions.

Too little attention has as yet been paid by the European, but more especially the British practitioner, to the advantages offered, even within the boundaries of the United States, for climatic treatment—advantages pre-eminent in possessing kindred customs and language, and the comforts, usages and appliances of civilization.

This, however, is of minor importance as affecting the value of the work in this country; while for exhaustive treatment of subject, soundness and reliability of dicta, and eminently readable style, terse yet lucid, it merits our hearty approval.

F. W. R.

## SELECTIONS.

*New York Medical and Surgical Society.—Discussion on Diphtheria.*—Dr. ALLEN stated that since the last meeting he had met with another case of diphtheria, which he still had under treatment. A week ago, Thursday (June 26), a little German girl complained of a sore neck. These symptoms continued until the following Tuesday, when she experienced difficulty in swallowing. Her mother resorted to various domestic remedies, but to no purpose. The day following she was seized with a fever, which, along with the dysphagia, increased very much in severity, and I was sent for. I arrived in the afternoon about five o'clock, and found the patient very much prostrated; the pulse 130 per minute, and weak; breathing was rapid and somewhat labored, and there was considerable dysphagia present. I immediately had the child taken up, and on examining the throat, found both tonsils covered with the diphtheritic membrane, the uvula was slightly cedematous, and the pharynx was lined as far down as I could see. The examination was made with much difficulty, as it seemed to give the child a great deal of pain. I gave the citrate of quinine and iron, with brandy and beef tea internally, using locally Labarraque's solution. I saw the child the next morning, and found that the upper portion of the tonsil was less covered with exudation than it had been, but in other respects no change in the general symptoms was noticed. The treatment was continued, and at my visit in the afternoon I found still less of the exudation, and the pulse was more full and rapid. I then suspended the use of the citrate of iron and quinine, and ordered instead the spirits of mindererus with an excess of ammonia, continuing the beef tea and brandy. I also recognised that the case was complicated with pneumonia of the left side, which had passed into the second stage without the knowledge, on my part, of its existence before. This morning (Saturday), about four o'clock, I found the child suffering from croupy symptoms, and on inspection of the throat, I discovered that the exudation had almost entirely cleared off, only showing itself upon the epiglottis. I then stopped the sp. mind. and gave a grain of calomel every hour, and continued the rest of the treatment. At eight o'clock that morning I visited the case again, and at that time in company with Dr. Bloodgood. We decided to continue the administration of the calomel, and give quinine along with it. This afternoon about three o'clock I saw the child again, and found that the parents, thinking that the child was going to die, had discontinued the treatment about two hours before. There

was very great difficulty in breathing, the air seemed to come through a perfectly dry tube, and at the end of two or three jerking sort of expirations, an inspiration would follow. I then told the father to give the child every fifteen minutes the syrup of ipecac until free emesis should follow. He did so. I called there just before I started to attend this meeting, and learned that in the interval three separate pieces of membrane had been expelled by vomiting, and that the patient in consequence felt very much easier. The last directions left with the father, were to repeat the administration of the remedy in the hope that some more of the exudation might be removed. The pneumonia has extended into the other lung, and there is now marked tubular breathing on both sides of the chest. Dr. A., in conclusion, mentioned that there was no scarlet fever in the family.

Dr. BULKLEY stated that he had seen, within the last five years, four well marked cases of diphtheria, two of which had occurred within the last two months. All these were connected, indirectly, with scarlet fever.

Dr. McCREADY stated that he had seen within two or three months two cases of diphtheria, which were by no means very severe, although in both instances they occurred in very unfavorable subjects, they being of a marked strumous diathesis. The first child had a large patch of membrane on but one tonsil, the pulse was frequent, there was a good deal of soreness of the throat, and also some swelling about the glands of the neck. The severity of the disease was broken in a couple of days, the membrane commenced then to disappear, and at the end of the fifth day was gone entirely. The convalescence was slow but perfect. In the second case the membrane existed on both tonsils, and the mode of its disappearance was the same as in the other case. The treatment in both consisted in the administration of the *tr. mur. ferri* in doses of three or four drops every two hours, together with wine whey, and good regimen.

Dr. WILKES stated that he had seen three well marked cases of this disease, and all of them were quite severe, and quite characteristic. He did not think it was possible to confound it with croup or the ordinary sore throat.

Dr. BUCK gave the following particulars of twelve cases of diphtheritic croup which he had met with since 1849. All these cases were children from three and a half to ten years of age; seven were males, and five were females; three were attacked in Oct., three in Nov., and one in each of the following months: Dec., Jan., Feb., March, April, and May. Of the twelve four recovered and eight died. Of the eight that died,

six were tracheotomized; of the four that recovered, none were operated upon. All the twelve were unequivocal cases, and were complicated with laryngeal symptoms; with but two exceptions, the exudation was seen in the fauces, and upon one of these tracheotomy was performed. This patient, a young child, survived twenty-three days after the operation, and the wound, together with a blistered surface which existed before the operation, became covered with diphtheritic membrane.—In all, the early symptoms were those of sore throat, preceded in some instances by chilliness and fever, then followed by cough and the ordinary croupy symptoms. Those that were tracheotomized survived from thirty-six hours to twenty-three days, and all of them died in consequence of the extension of the disease into the air passages. In the child that survived the longest, there were convulsions complicating the case, and at the autopsy, there were discovered traces of the existence of pleuro-pneumonia. In all that recovered calomel was given, and the nitrate of silver was applied locally. In two of them the cinnibar fumigations were used in addition. In answer to a question from Dr. Bulkley, Dr. Buck stated that in all his cases the disease extended to the larynx and gave rise to croupy symptoms, and he was inclined to group them under the general head of diphtheritic croup.

DR. MCCREADY could not see where the dividing line could be drawn between diphtheria and croup. We discover a patch of yellowish membrane upon the tonsil, pharynx, and velum of a child who has a little sore throat, and is slightly feverish. The fever increases, the child begins to have difficult deglutition, and too soon the alarming symptoms of croup show themselves. That train of symptoms may last from three or four days to a fortnight, but how they can be distinguished from a case of diphtheria, I am at a loss to determine. They seemed to him to be the same disease.

Dr. WATSON was of the opinion that diphtheria *was* croup, if the membrane extended into the larynx and gave rise to croupy symptoms.

Dr. BUCK thought that the particular character of the disease depended upon a more or less inflammatory diathesis at different seasons of the year.

Dr. CLARK stated that about one half his cases died in consequence of the effects of the disease upon the general system, and not of any mechanical obstruction. He had seen since the last meeting, three more cases, and of these one recovered. One was peculiar in certain respects, and bears upon the question whether or not this disease has any relation to scarlet fever. This patient was eight years of age. On the

third of January the family physician was called, and on examination of the throat, discovered the existence of membranous matter upon the fauces, and he anticipated all the unpleasant results of its extension. The local treatment consisted in the application of nitrate of silver, together with five grains of quinine twice a day. In the course of four days the membrane became loosened and was removed by the forceps. At that time the disease showed no tendency to extend. Within twelve hours after, symptoms which finally ended in scarlet fever came on, and the throat during all that time was very sore. Recovery was commencing in the usual way, when the patient was seized with a new set of febrile symptoms, and in two days after, the full, irregular crescentic eruption of measles made its appearance. The measles took its usual course, and on the subsidence of the eruption new patches appeared on the fauces. On the third day after, this membrane reappeared, and I was called to see the case; then the fauces were covered; a broad patch of exudation which concealed the surface of the velum to a considerable extent, and also the tonsils, extended into the posterior nares, and forward so far that it could be seen in the nostrils. The physician had previously removed from the last-mentioned place, with a pair of curved forceps, long ribands of membrane. In a sort of vomiting effort, the child threw up a large quantity of tough leathery membrane. During all this time there was no marked obstruction to the respiration. When I saw the child, however, the respiration was exceedingly rapid, there was a moan at each inspiration, the pulse 140, and the surface and nails were blue. I predicted an unfavorable issue, notwithstanding there was no appearance of any membrane in the larynx. The evidence of poisoning of the blood became more and more apparent, the blue appearance of the surface continued, and in two days after she died. In the meantime the membrane had made its appearance upon a little sore on the lip, and had extended from it as a centre, a considerable distance over the surrounding apparently healthy tissue. The case is interesting when we take into account the fact that with this diphtheritic diathesis upon her, this girl went through scarlet fever and measles, had a very sore throat during the prevalence of the former disease, yet there was no diphtheritic membrane; and as the convalescence from measles was commencing the exudation appeared, and the disease progressed to a fatal termination without any serious obstruction to the air passages. In answer to a question from Dr. Elliot, Dr. Clark stated that he had met with no case that had terminated in convulsions.

Dr. CLARK stated that on the evening after the last meeting he was called in consultation by Dr. Crane to visit a family in Elizabeth, N. J. Six, out of eight, children were suffering at the same time from scarlet fever, and one was lying dead in the house. Three out of the six children presented diphtheritic membrane in the fauces, and the remaining three had swollen tonsils with more or less inflammation of the throat. One of them had some white spots upon the inner surface of one of the tonsils, which at first looked a little like membrane, but afterwards turned out to be nothing more than a white secretion in the follicles. Two of them were at that time, as was supposed, desperately sick, and in one of these the membrane was distinctly discoverable in the nasal passages. The voice was a mere cry. The breathing was not so much obstructed as in croup, but sounded as if a valvular structure was playing up and down over the opening of the larynx; and we took it for granted that if the membrane had not already, it would eventually, extend into that portion of the breathing apparatus. The pulse was 140, and the intelligence nearly abolished. The patient was lying with her eyes closed, paying no attention to anything that was said, and considerable force had to be used to open the mouth. She moaned with almost every breath, though occasionally she would get a little quiet and seem to be asleep. This child finally recovered.

In one of the other children, the nasal passages were entirely plugged up by the drying of the secretions that flowed down from the external opening. The constitutional symptoms with him too were very marked. His pulse was the same as the others, but instead of being semi-comatose, he was restless, dozing continually. He lived nearly a week from the time I refer to, and apparently died from exhaustion, the result of the occurrence of numerous ulcerations very much after the manner of bed sores. It struck him that this latter feature of the disease was an evidence of the constitutional influence of the poison. The father, who was fifty-seven years of age, also had the diphtheritic exudation in the fauces, but in him none of the symptoms of scarlet fever had presented themselves. He, however, had the same character of valvular breathing as noticed in the daughter. His tonsils and velum were very much swollen, and the glands on the outside of the neck moderately so. The moment he lost consciousness in sleep, his breathing would stop as if something had passed into the opening of the larynx and prevented the entrance of air. The inspiration alone was obstructed. His friends were unwilling to allow him to sleep at such times for fear he would suffocate. This difficulty of breathing did not seem to me to be depend-

ent upon the existence of a membrane, but upon the swollen condition of the hanging portion of the fauces, which dropped fairly down upon the top of the larynx. As soon as the inflammation subsided this symptom passed off. At the time we saw him he had been in a state of active delirium for forty hours; his pulse was about 100 per minute. He finally recovered. The treatment for all these cases was about the same; pretty active stimulation with alcohol and the very free use of sulphate of quinine, and the local applications of nitrate of silver in solution. There was a circumstance that interested me in connexion with the two children who had the membrane in its worst form, relative to scarlet fever. In the girl, the eruption was out full for eight days, and when we saw her was perhaps subsiding a little; in the boy, the symptoms had been out eleven days, and was still vivid. Desquamation was quite active, and the scales were standing out, attached to the surface by their edges, in all possible directions; rubbing these off, the eruption could be seen as on the second or third day. The urine in these cases was not examined.

Dr. WILKES stated that he had met with an attack of diphtheria in a patient seventy-two years of age.

Dr. MCCREADY within the last four weeks had been called to four cases of diphtheria following scarlet fever; two of these terminated fatally very soon after he saw them. In both the pulse was exceedingly frequent; there was a good deal of restlessness present, and the membrane covered the posterior part of the fauces, extending to the windpipe. The third case was somewhat similar in character as far as symptoms were concerned.

The first case was one of those which some time ago would have been called croup. I was called in consultation to see a stout boy, three years of age, with a pulse not much over 100, skin a little warm, and face somewhat flushed. I was told that there was ulceration about the throat, but no false membrane. On examination, however, the so-called ulceration was found covered with an ashy-colored patch of membrane, the child was also quite hoarse, and had the regular croupy cough. I did not see the case a second time, but read of its fatal termination a week after in the newspaper. The case agreed in every respect with the description which foreign writers give to croup.

Dr. WARRE had seen one additional case since the last meeting:—A young lady, twenty years of age, was attacked on Wednesday last with what she supposed to be "chills and fever." She had a fair chill, followed by fever, a good deal of pain in the back, and also a sore throat. I was sent for on

Thursday afternoon, about thirty hours after she was first attacked. Her pulse was 130; she had a thickly-coated tongue, a severe pain in the back of the head and post-cervical region; the skin was cold and covered with a clammy perspiration. On looking into the throat, both tonsils were covered with a thick white deposit, which I am compelled to recognise as diphtheritic. I immediately placed her upon the use of quinine in two grain doses every two hours, and directed wine- whey to be given with the utmost freedom. Her skin was rubbed to get up an active circulation, and at bed-time opium was added to the quinine. I saw her yesterday morning, and the symptoms were decidedly moderated. Yesterday she was a good deal better; and to-day I found her very comfortable. The exudation has disappeared, leaving in its place a strawberry-roughness. The pulse is about 90, and has considerable force. No local treatment was employed.

Dr. METCALFE next made the following statement:—Since the beginning of the winter I have had ten cases of this disease, six of which I have seen in consultation. There have been seven cases in which the diphtheritic deposit affected the throat mainly, in the others the Schneiderian membrane was the principal seat of the exudation. The first case was a child three years of age, who was dying when I saw it; both tonsils and a part of the velum were covered with the membrane. The patient died comatose. The next was the sister of this child, who presented the exudation on each tonsil, the palate, and in the nostrils; there was a good deal of constitutional excitement, with occasional delirium, present. This case terminated favorably after a fortnight's illness. The third case was a brother of the last, eight months old; the membrane was situated on the surface of the tonsils, and invaded a small extent of the palate. This child recovered after four weeks illness. The uncle, who was in the house, convalescent from measles, had a slight diphtheritic patch on the palate. The mother also, had some trouble about the throat, her tonsils were much reddened, and the peculiar coating could be scraped from their surfaces without much difficulty. The constitutional disturbances were very trifling, and in two or three days she was entirely recovered. The next was a little girl four years old; I saw her on the next morning after the night she was attacked, when I found both tonsils almost completely covered with the membrane. The pulse ranged from 160 to 180. The breath was horribly fetid. The exudation in the course of the next day spread so as to cover the palate, and the grave symptoms increasing, the child died of apnoea two days after. The next was a child twelve years old, of a delicate constitu-

tion, who was taken on a Sunday morning, the membrane covering both tonsils and the edge of the soft palate. On Monday she was somewhat better; on Tuesday the fever subsided, and the membrane disappeared. That night the membrane reappeared, and extended into the nostrils; together with this there was attendant an immense tumefaction of one side of the neck. In consequence of this, there was a good deal of constitutional excitement, delirium, and difficulty of deglutition. The child, after making us believe for the greater part of four days that she was going to die, finally became convalescent. In this connexion Dr. Metcalfe exhibited a beautiful cast of membrane which had separated itself from the tonsils. Another case was of a young man, a member of the class at the University. He was taken sick on Saturday, and showed the patches in his throat the day following, when he experienced some difficulty in deglutition; had fever debility and quickness of the pulse. These symptoms continued for three days; he suffering a great deal without being, as I thought in positive danger. On the fifth day after the commencement of the attack, he was suddenly taken with a rigor, his skin was cold and covered with perspiration—respiration forty per minute. He could not lie down for a minute without having symptoms of suffocation. The gentleman who saw him with me was of the opinion that the case would terminate fatally very soon; the patient, however, recovered, and was able to return home on the Monday following. These are the only cases worthy of mention; of the rest, with but one exception there was very little constitutional excitement—some quickness of the pulse, pallor of the body, restlessness, pain in swallowing, and the occurrence of a well-marked membrane, with nasal defunction—and they all got well. I have not used quinine in any of these cases, but in its stead the mur. tinct. ferri in twenty-drop doses every two hours to adults, decreasing the quantity according to the age of the patient. Besides this, I give plenty of beef-tea, milk-punch, and wine whey. I have used the sol. of nit. silver locally, but can't say that I have derived any benefit from it. I have given the chlorate of potash as a gargle, but there again I failed in obtaining any good results. In conclusion, Dr. Metcalfe referred to a new remedy, the iod. of bromine, which had been brought to his notice by a physician in Long Island. It was used locally in the strength of fifteen drops to eight ounces of syrup, and was of great service in correcting the fetor of the breath. He (Dr. M.) had succeeded very well with the remedy, and advised the members to give it a trial.

Dr. WATSON referred to the case of a gentleman who, within the last six weeks, was attacked four different times with

sudden fits of suffocation, which, after existing for a time, would be followed by the discharge of a plug from the bronchial tubes, when immediate relief would ensue. Dr. W. attended him in one of these attacks, and stated that the plug raised at that time was about two inches long, and about as thick around as the forefinger. The extremities of this mass were much softened while the centre was hard and tough. He thought it possible that the condition of things referred to might have more or less to do with the epidemic of diphtherite.—*Am. Med. Times.*

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**CAN A WOMAN REMAIN IGNORANT OF HER PREGNANCY UP TO THE TIME OF HER DELIVERY?**

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*To the Editor of the London Lancet.*

SIR,—The following case I can vouch for as decisively affirmative upon the above medico-legal point;—

On the 24th ultimo I was summoned to Mrs. R——, aged twenty-eight, married, with one child four years old. She stated that for the last twelve-months she had been ailing, and considered to be in a consumption; that a month or two before last Christmas she began to vomit blood, and, continuing to do so, she in March last consulted Dr. Tyler Smith, who, to her great surprise, pronounced her to be seven months pregnant. Up to the time of her labor the catamenia had been quite regular; she had suffered from none of the ordinary sympathetic ailments; had been sensible of no alterations in the breasts; and, notwithstanding Dr. Tyler Smith's opinion, she had not been able to detect any enlargement of her abdomen, or any sensation whatever of the child's movements. Had she not been informed of her pregnancy, she would undoubtedly have remained ignorant of her situation to the very last.

The liquor amnii was abundant, and the child a full-grown lively boy.

I am, Sir, yours, &c.,

JAMES DUNCAN, M. D.

Henrietta-street, Covent-Garden, }  
July 12th, 1860. }

We have known similar cases in which married women, who had previously borne children, did not believe they were pregnant until delivery was at hand.—*Ed. L.*

# TRANSMISSION OF SECONDARY SYPHILIS.

To the Editor of the London Lancet.

SIR,—The reviewer of Mr. Harrison's book on Venereal Diseases, mentions the author's opinions respecting the transmission of secondary syphilis. Mr. Harrison thinks that this disease, which is supposed to be directly conveyed from the male to the female, does, in reality, reach the latter very seldom otherwise than by the intermediate action of the foetus contaminated by the father.

I am certainly extremely happy to be supported by Mr. Harrison's authority, but I must beg to observe that not only have I long ago expressed this opinion, but also based it upon the very arguments that Mr. Harrison brings forward. The author, for instance, says—

1st. That in most of the cases of ascertained secondary transmission the disease has been conveyed from the male to the female, and not from the female to the male.

2ndly. That in such cases the first symptoms which are observed upon the woman appear in regions which leave no room for suspecting infection by coitus or any other contact.

3rdly. That the female then presents neither primary chancre nor bubo.

I repeat that I am very glad to see my arguments sanctioned by the approbation of the learned author, who doubtless has clinically verified their value. But I must remind your readers that these arguments have been put forward by myself, pretty well in the same words as used by Mr. Harrison, in my work entitled "On the New Doctrines of Syphilis," (Paris 1858.)

P. DIDAY.

Lyons, 1860.

*Special Hospitals.*—A movement having been set on foot to found a Special Hospital for the treatment of stone and diseases of the urinary organs, in London, a number of the most prominent physicians of that city, among whom are Brodie, South, Latham, Watson, etc., have published an address in the Lancet objecting to this, and expressing their opinion on special hospitals generally, as follows :

"The practice is injurious, First, because in the maintenance of numerous small establishments the funds designed for the direct relief of the sick poor are wasted in the useless multiplication of expensive buildings, salaries and hospital appliances, and in the custom of constantly advertising to attract public attention.

"Secondly, because the public is led to believe that particular classes of diseases can be more successfully treated in the small special institutions than in the general hospitals—an assumption directly contrary to evidence; the fact being that the resources of the general hospitals are in every respect superior to those of the special institutions alluded to.

"Thirdly, because it is essential for the interests of the public, with a view to the efficient education of students preparing for the practice of the medical profession, that all forms of disease should, as far as possible, be collected in the general hospitals to which medical schools are attached."

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*Somnambulists Fined.*—In Paris, professional somnambulists have frequently been condemned to fine and imprisonment for obtaining money on pretext of indicating occult facts. Two persons named Nicholas, man and wife, were this week committed to prison for one month, and each fined 50 fr., for swindling out of 20 fr., a man who had been robbed, and to whom they pretended falsely to indicate the thieves.

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## EDITORIAL.

### ILLINOIS STATE MEDICAL SOCIETY.

In accordance with the instructions of the State Medical Society at its last annual meeting, *notice* is hereby given that the annual meeting for 1861, will be held on the *First Tuesday* in *May* next, in the City of Jacksonville.

N. S. DAVIS, M. D.,

*Per. Sec'y Illinois State Medical Society.*

Chicago, Aug. 28th, 1860.

## MEDICAL SCHOOLS IN CHICAGO.

The Annual Announcements of the two Medical Schools in this city have been issued, and the time is fast approaching for the Commencement of their respective Annual College terms.

The Announcement of the *Rush Medical College*, indicates no change since the last term, either in the Faculty or the general course of instruction. To such students as are desirous of skimming over all the branches, or more properly, of following the lecturers over a part of each branch for sixteen weeks, without thoroughly reviewing any, the Rush Medical College affords as strong inducements as any similarly organized school in the country. Its regular term commences on the *first* Monday in November, and continues sixteen weeks; but a preliminary course of Lectures and Clinical instruction will be given during the month of October.

The Announcement of the Medical Department of Lind University, also shows no change in the plan of organization, and the courses of instruction adopted by that institution, and but one change in the Faculty. When the first Annual Announcement of the University was issued, the Chair of *Materia Medica* was vacant. Subsequently the Chair was filled by transferring other members of the Faculty in such a way as to give the Chair of Anatomy to Prof. T. Deville. At the close of the term, Prof. Deville resigned, and the other members of the Faculty were restored to the Chairs originally assigned to them, leaving that of *Materia Medica* again vacant. This Chair has now been filled by the appointment of A. L. McArthur, M. D., of Joliet, Ill.

Prof. McArthur pursued the study of medicine in this State, and several years since graduated in Rush Medical College. Subsequently he attended the Schools and Hospitals of Philadelphia during the full college term, and received an additional Diploma from the University of Pennsylvania. Since that time he has resided in Joliet, where he has acquired an extensive and profitable practice. Though in the prime of life, he will bring to the duties of his Chair, a degree of scholarship and practical experience which cannot fail to give him a high reputation as a teacher. The regular lecture term in the

University commences on the second Monday in October, and continues until the first Monday in March. It is founded on the principle, that college instruction in medicine, like that in all other sciences, should be progressive and adapted to the stage of advancement of the student.

Hence, each term is divided into Junior and Senior departments. The first embraces Descriptive Anatomy, Physiology and Histology, Materia Medica, Pathology and Public Hygiene, and Inorganic Chemistry, and is designed for students attending their first course. The second or Senior department embraces Surgical Anatomy, Organic Chemistry, and Practical Medicine, Surgery, and Obstetrics with diseases of women and children, and full courses of Clinical Medicine and Surgery. Practical Anatomy in the dissecting room, and a full course of lectures on Medical Jurisprudence are open to the students in both departments. By adopting this plan, the Trustees and Faculty of the University, designed to accomplish the following important objects: First, to induce a more systematic or methodical mode of pursuing the study of Medicine. Second, to compel the student to acquire a competent knowledge of those more elementary branches, which must constitute the foundation of all correct medical education, before engrossing the mind with the details of the practical branches. Third, by increasing the number of Professorships, dividing and lengthening the term, to insure full instruction in the very important departments of Organic Chemistry, Histology, Surgical Anatomy, and Medical Jurisprudence, branches that are very briefly discussed or not taught at all in most of the Medical Colleges of this country. Fourth, by requiring the student to attend a smaller number of lectures each day, and increasing the length of time, to insure him sufficient time to digest what he hears, and to acquire a mental discipline of the utmost value to the practising physician. Fifth, to give that prominence to *Clinical Medicine and Surgery*, which their importance entitles them to, by devoting an hour every morning to Clinical instruction in the Mercy Hospital, and an additional hour every Wednesday and Saturday at the Dispensary in the College. That the actual attainment of these objects would greatly elevate the standard of Medical education, and correspondingly

benefit both the profession and the community none can deny. That the plan of organization and instruction adopted by the Lind University, will practically accomplish these purposes, the experience of the last session afforded abundant proof. We learn from the Secretary that the prospects are good for a largely increased class the coming lecture term. It should be mentioned that while the Junior and Senior departments are kept perfectly distinct, and first course students are *required* to take the full Junior course and sustain a thorough examination on the branches taught therein, yet, the lecture hours are so arranged in the two departments, that any student in the junior class who wishes to spend more time in the Lecture room, can attend any part on the whole of the courses on Practical Medicine, Surgery, and Obstetrics, without additional charge. And on the other hand, the students in the senior class can also, if they choose, attend again any part on all of the courses on Anatomy, and Physiology and Histology, in the junior department.

We say then, with all candor and sincerity, to the profession of the north-west, that, *Chicago*, with two medical schools, one on the ordinary plan and the other on a plan embracing a more methodical and extended system of instruction than any other school in this country; with three Hospitals and two or three Dispensaries accessible for clinical instruction, presents in every respect as good advantages for acquiring a complete and thoroughly practical medical education as any other city in the Union.

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*Museum and Library of the Medical Department of the Lind University.*—We should have mentioned in giving an account of the Medical Schools in this city, that the Trustees of the University have secured for the museum of that school, the whole collection of Anatomical preparations, etc., brought from Paris by Prof. Deville. Such additions have also been made in other departments, as to render the means of illustration in all the branches of medical science very full and satisfactory. The Library of the same school has also been increased to nearly 1,000 volumes, accessible to the medical classes.

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## THE CHICAGO MEDICAL EXAMINER.

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EDITED BY

N. S. DAVIS, M. D., AND E. A. STEELE, M. D.

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